HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

VOLUME 18, NO. 6, ABSTRACTS 798-950. JUNE 1978

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HOSPITAL ABSTRACTS

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HOSPITALS IN GREAT BRITAIN

See Abstract No. 806

HOSPITALS IN OTHER COUNTRIES

See also Abstract Nos. 817, 847, 853-854

798. PERIS, R., NOGUERA, E. and MARTIN, F. Dotación hospitalaria del Pais Valenciano. **[Allocation of hospital beds in the Valencia Region of Spain.]** *Estudios sobre Hospitales*, Barcelona, 1977, no. 82, pp. 23-30.

Six tables, one map, one graph, and a short commentary summarize the present state of hospital bed provision in the Valencia Region of Spain. There are 99 hospitals altogether, with a total of 14,809 beds, or .45 beds per 1,000 inhabitants. There is a general shortage of acute beds. Hospitals tend to be concentrated in the large centres of population, and provision in rural areas is very poor. The central government is responsible for 11.30 per cent of beds, local corporations for 33.28 per cent, and the social security for 31.64 per cent. To achieve a ratio of 10 beds per 1,000 inhabitants, another 18,048 beds will be required.

799. JANSTAD, H. and ERICHS, K. Malmö och sjukvården. **[Malmö's hospital services.]** *Landstingens Tidskrift*, Stockholm, 1977, Oct., vol. 64, no. 11, pp. 15-30.

This series of nine short, illustrated papers deals with various aspects of the health services of Malmö. The subjects are as follows: new hospitals and out-patient facilities for long term care to relieve acute hospitals; a new 264-bed ultra modern surgical block to cost 110 million kroner, construction to start at the end of 1980; a kidney transplant centre at the Malmö General Hospital; increased facilities for remedial gymnastics, which are believed to be the best in Sweden; health care facilities enabling the elderly to remain in their home environment; facilities for physically disabled children; care of alcoholics; an interview with the retiring director of health services; and an interview with the newly appointed director of health services.

800. Los servicios sanitarios y hospitalarios en el Japon. **[Hospital and health services in Japan.]** *Estudios sobre Hospitales*, Barcelona, 1977, no. 84, pp. 23-33.

This is an outline of health and hospital provision in Japan. The government is responsible for health care in three areas: industry, schools, and public health, and only the third of these is under the jurisdiction of the Ministry of Health. The majority of the population is covered by health insurance schemes. Hospital provision amounts to 12.8 beds per 1,000 inhabitants. No distinction is made between chronic and acute cases, and the average length of hospital stay was 34 days in 1974. About 75 per cent of hospitals are privately owned; the hospital director must be medically qualified. In 1974, 3.95 per cent of the Gross National Product was devoted to health

care; 13.5 per cent of this was contributed directly by the government. As in the West, health costs have been affected by inflation: costs rose by 35.8 per cent in 1974 and by 19 per cent in 1975. Other problems specific to Japan include the fact that the country is passing through a period of rapid social change.

801. CAMPOS da PAZ, A. and others. Hospital para enfermedades del aparato locomotor, Brasilia: plan de organizacion de un programa regional de ortopedia y rehabilitacion. **[Hospital for diseases of the locomotor system, Brasilia: a plan for the development of a regional orthopaedic and rehabilitation scheme.]** *Boletin de la Oficina Sanitaria Panamericana*, Washington, 1977, Oct., vol. 83, no. 4, pp. 346-352.

In 1969 the Brazilian Government decided to expand the Sarah Kubitschek Rehabilitation Centre in Brasilia into a hospital which would handle all aspects of the treatment of the locomotor system. Work is expected to be completed by early 1979. The new hospital is envisaged as a co-ordinating nucleus for health services within its specialty over a wide area that includes the northern, north-eastern and central western areas of Brazil. The hospital will provide treatment for complex cases referred by other hospitals and institutions and will establish a network of trained staff working in all communities regardless of resources. The hospital promotes research aimed at the development of prototype models of health and orthopaedic equipment for the disabled, and the early detection and treatment of locomotor diseases. The concept of progressive patient care will govern the overall orientation in the hospital, and consequently sophisticated equipment can be concentrated within a small area and costs rationalized.

802. HÉBERT. La politique hospitalière du gouvernement peut-elle changer? **[The hospital policy of the government–can it be changed?]** *Hospitalisation Nouvelle*, Paris, 1977, Nov., no. 64, pp. 40-51.

The Private Hospital Union has always objected to the privileged position assigned by successive French governments to the public hospital sector which has been encouraged to expand at the expense of the private sector. The PHU would like to see the establishment of a contract between the medical profession, the insurance companies, and the government, which would confer official status on the private hospitals and permit the doctors in them to play a role in medical education and research, and provide treatment for emergency cases. The fact that the present Minister of Health, Madame Veil, has decided to stabilize or even reduce the overall level of hospital facilities and restructure the public hospital tariff system suggests that there may at last be some hope of changes in government policy.

PLANNING, DESIGN AND CONSTRUCTION

See also Abstract No. 866

803. PAUCHARD, P. Pourquoi choisir une construction industrialisée? **[Why choose an industrialized building?]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, Jan., vol. 33, no. 388, pp. 62-66.

The author describes how a combination of factors—lack of hospital facilities,

procedural difficulties, the delays attributable to traditional construction methods, and sociological, technical, and financial constraints—led to a re-appraisal of hospital investment policy some 10 years ago. One solution to the problems encountered was the use of industrial construction techniques for new hospitals. The first hospital to be built in this way was the 300-bed hospital at Beaune; from conception to completion required less than three years. The design, with some modifications, has since been used on other sites.

804. MCLACHLAN, G., editor. **Framework and design for planning: uses of information in the NHS. Problems and progress in medical care: essays in current research.** 10th series. London, Oxford University Press, for Nuffield Provincial Hospitals Trust, 1977, ix, 153pp. £3.50

The essays in this book are concerned with the production and use of information for planning and shaping health services. Aspects considered include: planning hospital services; planning local services; an information service for planning and managing a National Health Service district; and priorities in preventive medicine. An appendix presents a numerical approach to the assessment of priorities.

BUILDING COSTS

805. WHITEHEAD, A. **How not to drop bricks.** *Health & Social Service Journal*, London, 1977, Dec. 9, vol. 87, no. 4570, p. 1675.

In setting up a hospital building programme, regional objectives must be formulated, taking into account existing facilities, population trends and a survey of existing buildings. To promote good management and, where possible, to prevent delay, each project should be divided into stages, in accordance with the Procedure for the Planning and Processing of Individual Building Projects (Capricode). Architects often do not follow these stages because they are more familiar with the Royal Institute of British Architects plan of work. A particular problem arises in hospital building, where a high proportion of the cost is in the services, and the design teams for building and services are provided by separate organizations. Programming a level of capital expenditure higher than that originally anticipated would help to overcome the difficulties arising from following Capricode procedures.

HOSPITAL DESIGN

See Abstract No. 808

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See also Abstract Nos. 799, 801

806. **Northern RHA Freeman Hospital.** *Hospital Development*, London, 1978, Jan./Feb., vol. 6, no. 1, pp. 12-13.

The multi-million pound Freeman Hospital development in Newcastle includes accommodation for up to 813 patients and the Northern Regional Health Authority's

specialties of urology and cardiothoracic medicine and surgery. The hospital is formed of three principal buildings; main ward block, central services block and cardiothoracic block, linked by pedestrian access and service corridors. The contract also includes workshop areas, an energy centre, roads and sewers, and landscaping. The adjacent staff residential site comprises 342 units of accommodation in five multi-storey blocks. A plan and full details of the building and services are given.

DESIGN OF SPECIAL DEPARTMENTS

See also Abstract No. 897

807. MOSEL, H. A. von der. **Common mistakes in planning intensive care units.** *Hospital Engineering*, London, 1977, June, vol. 31, no. 5, pp. 11, 14-16.

This paper discusses the 10 most common mistakes in the design of intensive care units (ICUs): (i) creation of an ICU for a specialty which is not otherwise represented in the hospital; (ii) incorrect number of intensive care beds; (iii) wrong location; (iv) wrong size; (v) insufficient floor space; (vi) wrong physical layout of the patient area; (vii) wrong physical arrangement of the area around the bed and of the bed itself; (viii) insufficient electrical outlets; (ix) use of fluorescent lights; and (x) over-instrumentation.

DESIGN OF SPECIAL HOSPITALS OR UNITS

See also Abstract No. 950

808. SPRING, M. **Pitched just right.** *Building*, London, 1978, Jan. 20, vol. 234, no. 7020, pp. 86-90.

The Gloucester Centre, on the site of the new Peterborough Hospital, provides accommodation for patients severely handicapped, not only mentally but also physically in many cases. The Derwent industrialized building system was used with two major developments to achieve domestic scale and character: a monopitch roof and a brickwork external skin that projected out in front of the clapboard roof gable. The centre comprises a central activities area surrounded by five separate residential blocks, four for adults and one for children. Each of these blocks consists of two self-contained 12-bed units. A plan of one of the blocks, a site plan and 11 photographs are included.

ENGINEERING SERVICES

INSTALLATIONS IN GENERAL

809. MAILLARD, C. Un plateau technique de services généraux: conception et mise en oeuvre. **[Planning engineering services: conception and practice.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, Jan., vol. 33, no. 388, pp. 121-125.

Because the general services—stores, laundry, kitchens, workshops, heating installations, garages, incinerators, and staff cloakrooms—at Gap General Hospital

required renovation, it was decided to draw up a comprehensive plan and resite them in more convenient locations. The work is being carried out in several stages and so far the oxygen centre, laundry, heating plant, workshops, incinerator block, and electrical installations have been brought together under one roof. The various stages of planning and construction are described with the aid of two maps, one ground-plan, and two tables.

ELECTRICAL INSTALLATIONS AND EQUIPMENT

See Abstract No. 848

TRANSPORT IN GENERAL

810. KAPPELER, D. P. Tecnica de manutencion para hospitales: necesidad imprescindible. **[Maintenance in hospitals: an essential need.]** *Policlinica*, Barcelona, 1977, Nov./Dec., no. 42, pp. 39-44.

This is a review of all the factors which must be taken into consideration when transport systems for goods within and between existing or new hospitals are being planned. The various planning stages, the specialist knowledge required, and the need to integrate external and internal transport systems are discussed. The author emphasizes the fact that an automated transport system can substantially reduce staff costs in the hospital. His article is accompanied by three diagrams which summarize his argument, and by three illustrations of a monorail transport system.

811. WALTON, T. R. **Managing a dispersed fleet of vehicles.** *Hospital Engineering*, London, 1977, June, vol. 31, no. 5, pp. 16-18.

The London Ambulance Service meets the ambulance needs of some eight million people who live within the 610 square miles area or who visit or come to work in the capital each day. To do so it has to deploy about 1,000 vehicles and 2,700 operational and control staff based at 75 stations. The service answers an average of 1,500 emergency and 9,000 routine calls daily. The area is divided into four divisions, each with a headquarters housing a small administration unit and a divisional control which deals with non-urgent calls. The central control at service headquarters operates 24 hours a day and deals with all emergency calls. In this paper the chief officer of the service reviews some of the problems of its management, dealing particularly with communications, managing the available resources, equipment and legal responsibilities.

HEATING

See Abstract No. 849

SANITARY EQUIPMENT AND FITTINGS

812. SHAW, F. A. **Water use, not water waste.** *Hospital Progress*, St. Louis, 1977, Dec., vol. 58, no. 12, pp. 74-75.

By the very nature of their work, hospitals use large amounts of water, but they

need not be water wasters. This paper suggests ways in which hospitals may reduce their consumption of water and at the same time also save energy. The areas covered are: laundries; cooling towers in air-conditioning; flush valves in water closets and urinals; dishwashers; water softeners; showers; and X-ray film washing machines.

EQUIPMENT, FITTINGS, FURNITURE

MEDICAL EQUIPMENT

See Abstract Nos. 841, 899

STAFF GENERALLY

STAFF COMPLEMENTS

See also Abstract Nos. 826, 945

813. LAPORTE. Au service des usagers: des investissements humains. **[At the service of the users: human investments.]** *Revue Hospitalière*, Paris, 1978, Jan., vol. 42, no. 307, i, pp. 115, 117, 119, 121-179.

This is a very wide-ranging survey. In Part one the reasons for the increases in the numbers of hospital staff over the last decade—the expansion in the number of hospital beds, the tendency to have only one or two beds per room, higher standards of care, higher expectations in regard to comfort on the part of the patient, advances in medicine and surgery—are examined at length. In Part two methods of controlling this expansion and the concomitant increases in costs are considered; these include standardization of staffing requirements, greater efficiency, improvements in and streamlining of the structure for nursing and paramedical staff training, the correction of disparities in staff status, and the possibilities of relieving the hospital of the burden of the costs of training paramedical staff. The report includes seven tables relating to the numbers of staff employed in French hospitals.

RECRUITMENT

See Abstract No. 944

CONDITIONS OF SERVICE

See also Abstract No. 827

814. KLEPPING, M. La condition médicale à l'hôpital: où en sont la médicine et les médecins dans l'hôpital? Où vont-ils? **[Medical conditions in the hospital: what are they like for doctors and medicine in hospital? Where are they going?** *Revue Hospitalière*, Paris, 1978, Jan., vol. 42, no. 307, i, pp. 97, 99-113.

This report contains a series of short articles on the position of doctors in hospitals

in relation to: (i) the administrative and architectural structure of the hospital; (ii) teaching in the hospital; (iii) the nursing staff; (iv) research; (v) careers; and (vi) the outside world. The general conclusions drawn are that the hospital of tomorrow will be conditioned by many factors of which the most important will be health policy, costs, technical developments, and the position of the medical staff.

STAFF MANAGEMENT

See Abstract Nos. 828-830, 842, 944

STAFF RELATIONS

815. BERKELEY, A. E. and BARNES, A., editors. **Labor relations in hospitals and health care facilities: proceedings of a conference presented by the American Arbitration Association and the Federal Mediation and Conciliation Service, June 10-11, 1975.** Washington, D.C., Bureau of National Affairs, 1976, viii, 102pp.

The proceedings of the conference entitled 'Chaos or Constructive Change' held at the Center for Adult Education of the University of Maryland on 10-11 June, 1975, are presented. The papers consider all aspects of labour relations in hospitals and health care centres. The three specific areas discussed are: background and legal framework of the National Labor Relations Act (NLRA) amendments; impact of the NLRA amendments on the parties—the unique nature of hospital negotiations; and the impasse resolution under the NLRA amendments. An appendix is included listing the guidelines for the Board of Inquiry established by the Federal Mediation and Conciliation Service.

STAFF TRAINING

See also Abstract Nos. 819, 822-823, 832-837, 843, 847, 875

816. KATZ, F. M. **Guidelines for evaluating a training programme for health personnel.** (WHO Offset Publications No. 38) Geneva, WHO, 1978, 35pp. Sw.fr.6

This report presents guidelines for evaluating a training scheme under four general headings corresponding to the phases of the evaluation; orientation; design of the evaluation; collection of information about the programme and its effects; and analysis and reporting. An annex is included containing suggestions for the application of the guidelines for an evaluation which is intended to illustrate procedures rather than provide a model evaluation report.

817. ASENJO, D. M. A. La influencia de la docencia en el programa funcional de la unidad de enfermeria. **[The influence of education on the organization of the unity of hospital care.]** *Estudios sobre Hospitales*, Barcelona, 1977, no. 82, pp. 31-42.

One of the functions of the university hospital is the education of undergraduate

and postgraduate medical students, nurses, midwives, medical social workers, and paramedical technicians. In the modern hospital emphasis is shifting away from the ward and towards the out-patient clinic, the emergency department, and the specialized unit. The general ward is not, in any case, the ideal setting for the instruction of the undergraduate, since the diseases seen there are unrepresentative, and bedside teaching can be unpleasant for the patient. The author discusses in general terms the training which should be given to future general practitioners and specialists, and the facilities which must be provided within the hospital—lecture theatres, demonstration theatres, meeting rooms, etc.

STAFF WELFARE

See also Abstract No. 835

818. ROBERT and others. La prévention: le promoteur de santé doit être dans la nation comme le poisson dans l'eau. **[Prevention: the promoter of health should be in the nation like a fish in the water.]** *Revue Hospitalière*, Paris, 1978, Jan., vol. 42, no. 307, i, pp. 181, 183, 185-204.

The authors compare the modern hospital to a citadel separated from the surrounding community by a moat. They examine how best the hospital can play a fuller role in the prevention of disease. Spheres for immediate action include the maternity clinic, screening units, vaccination units, family planning centres, centres for alcoholics, and the practice of preventive medicine among hospital staff. Proposals for further extensions of the hospital's role are less concrete but it is suggested that university hospitals might, through a regional health institute, co-ordinate or even control the activity of prevention outside the hospital.

SPECIAL CLASSES OF STAFF

ADMINISTRATIVE AND CLERICAL STAFF

819. RAVELO de TOVAR, A. Quelle formation, quel avenir pour les jeunes directeurs d'hôpitaux? **[What training, what future for the young hospital directors?]** *Hospitalier*, Mantes, 1977, Oct./Nov., no. 337, pp. 28-29.

The author discusses what he sees to be the short-comings in the training provided by the *École Nationale de la Santé Publique* for future hospital administrators. Theoretical instruction is confined to a period of five months in the students' first year and does not include the topics of health planning, epidemiology, health economics, or systems analysis. The second and third years are spent on on-the-job training in hospitals and the trainee administrator is sometimes treated as a stop-gap or doormat and given no opportunity to acquire useful experience.

820. LASSERRE, J. and MAZEREAU, G. 'Les risques du métier . . .' ou la responsabilité personnelle du directeur d'hopital. III. La responsabilité des directeurs d'hôpitaux psychiatriques en cas d'internement illégal. **[Risks at work . . . or the personal responsibility of the hospital director. III. The responsibility of hospital directors in psychiatric institutions in cases of illegal confinement.]** *Gestions Hospitalières*, Mantes, 1977, Nov., no. 170, pp. 779-780, 782-784, 786-787, 789-792.

In France a patient can be committed to a psychiatric hospital against his will in two ways. The first is by 'voluntary placing', when a request for admission is made in writing by a person who must specify the connection between himself and the patient; this request must be accompanied by a certificate issued not more than 15 days previously by a doctor not connected with the psychiatric hospital, and also a certificate issued not more than 24 hours previously by a doctor on the staff of the establishment. The second way is 'placing by the Court', on order from the Prefect, of any person 'whose state of alienation may compromise public order or the safety of persons'. The latter procedure is often used for alcoholics. Two cases in which the administrator of a psychiatric hospital was sued for wrongful committal of a patient are described and discussed, and the court's findings are criticized.

MEDICAL STAFF

See also Abstract Nos. 814, 868

821. WINTON, R. R. **The future of professional freedom.** London, Christian Medical Fellowship Publications, 1977, 14pp. £0.25

This is the text of an address given on 10 October, 1977, to members of the Medical Profession, at the invitation of the Christian Medical Fellowship. The meanings of 'profession' and 'freedom' within the medical context are examined together with the practical considerations.

822. PARKER, L. A. and BAIRD, M. A. **Continuing education by telephone: a party line for professionals.** *Hospitals*, Chicago, 1977, Nov. 16, vol. 51, no. 22, pp. 105-106, 108, 110-112.

Begun in 1965 to provide high-quality, low-cost continuing education to physicians in their home communities, the University of Wisconsin-Extension's Educational Telephone Network (ETN) now embraces the state's 72 counties and serves all health care professions. It operates five days a week from September to May from 0700 to 2200; the programmes vary from one to two hours in length and include a variety of formats. The technology is uncomplicated for the user and requires no special skill. In each hospital ETN contacts book rooms, put up notices and answer questions about programmes. Brief details are given of enrolment plans, programming, instructional techniques and costs.

823. MURRAY, T. S. and BARBER, J. H. **Undergraduate teaching of general practice in the U.K.** *Update*, London, 1978, Jan. 1, vol. 16, no. 1, pp. 39-42, 44, 46-47.

Of the 30 medical schools in the United Kingdom almost all include general practice as a formal part of the curriculum, but there is a great variation in the methods of

teaching. Undergraduate teaching of general practice is still in the early stages of development and the problem of whether it should be related to clinical medicine in the context of general practice, or to general practice as a career, remains unsolved in some schools. The appendix to the article describes: (i) the teaching methods used in the 18 established departments of general practice; and (ii) the state of development of general practice in the remaining 12 medical schools.

824. BUTTER, I. **Foreign medical graduates: a comparative study of state licensure policies.** (DHEW Publication No. (HRA) 77-3166) Rockville, Md., National Center for Health Services Research, 1976, viii, 80pp.

This is a condensed version of a report entitled 'State policies on limited and temporary licensure of foreign medical graduates' published in 1975 (NTIS No. PB 073). The objective of the study was to: (i) identify and describe the structure of current less-than-full licensure systems, their implementation from state to state and their operation with respect to foreign medical graduates; (ii) to provide the states with the tools necessary for evaluating their own licensure systems; and (iii) to apply the findings of the investigation to policy recommendations which consider the questions of uniformity in licensure methods and the effectiveness of competitive assurance. Aspects considered in this monograph include: classification of state licensure systems; full and less-than-full systems; and policy recommendations. Two appendices are included of tables, figures, and methodologies for ranking states according to their policies. A select list of references on medical licensure is included.

NURSING STAFF

See also Abstract Nos. 838, 850, 890, 924, 945

825. MCELMURRY, B. **Illinois: State-wide Council for Nursing Research.** *International Journal of Nursing Studies*, Oxford, 1978, vol. 15, no. 1, pp. 17-22.

During 1974 a team of researchers commissioned by the Illinois State Nurses Association (INA) undertook to identify research activities and the research interests and needs for nurses in Illinois. Data was obtained by questionnaire in 1975 and the results led the INA to establish the Council for Nursing Research. The Council aims to foster: participation in research activities; collaboration of nurses in all areas; identification and developments of support systems for research; dissemination of findings and utilization of results.

826. NORBY, R. B., FREUND, L. E. and WAGNER, B. **A nurse staffing system based upon assignment difficulty.** *Journal of Nursing Administration*, Wakefield, Mass., 1977, Nov., vol. 7, no. 9, pp. 2-24.

A description is given of the new method for calculating nurse staffing levels based upon a new concept—assignment difficulty. The instrument was developed by the Medicus Systems Corporation (USA) during 1975 and recognizes the relationship between care delivery and care quality. Some factors used in formulating staffing levels are: staff interviews to determine activity groupings for each unit and shift; measurement of patient dependency; identification of assignment elements by com-

bining activity groups with each patient dependency group; dividing need for staff of differing skill levels. Once the staffing recommendations are implemented the system can provide documentation for decision making and system self-correction.

827. AUSTIN, R. **Professionalism and the nature of nursing reward.** *Journal of Advanced Nursing*, Oxford, 1978, Jan., vol. 3, no. 1, pp. 9-23.

This is an examination of the relationships between the rewards of nursing and the work expectation general to professional groups, which formed one aspect of the author's doctoral thesis. Data was drawn from the sample of 320 nurses (of all grades from third-year students to Nursing Officer) in a provincial hospital group during 1973-4. It was found that job satisfaction was very important to nurses and that this was not equated with a desire for extrinsic rewards e.g. money, status or power. This, the author feels, is contrary to the extrinsic work rewards expectations being sought by the leaders of the nursing profession.

828. JACOBI, E. M. **The moral leadership of the nursing profession.** *Journal of Advanced Nursing*, Oxford, 1977, Nov., vol. 2, no. 6, pp. 561-569.

As the largest group of professional workers in the health care field, nurses possess the numbers to command a key role among health professionals. They must, however, assume a more visible and vital leadership role in the delivery of health care if nursing is to remain a viable profession. Particularly, there is a need for strong moral leadership in the profession. In 'moral leadership' the power of the leader is used to work with the group as a whole, while guiding individual members towards satisfaction and self-fulfilment. A critical evaluation of nursing's leadership capabilities should begin with definitions of the role and responsibility of nurses for leadership in the professional association. By its very nature, the professional association stands as the leadership mechanism of the profession and, by working through the association, nursing leadership can unify nursing forces, implement plans aimed at involving more nurses in health planning activities, and facilitate the involvement of individual nurses in determining the conditions of employment under which they practise.

829. BERRY, V. I. and REICHELT, P. A. **Using routinely collected data for staffing decisions.** *Hospitals*, Chicago, 1977, Nov. 16, vol. 51, no. 22, pp. 89, 90, 92.

It was obvious that resolution of nurse staffing problems at a large urban teaching hospital would require data which were not available from those routinely collected. As a result of attempting to use the available data, the following conclusions and recommendations were formulated: (i) data collection procedures should comprise a well-integrated, standardized information system; and (ii) a data system should be constructed on the basis of consensually validated guidelines that specify what data are to be collected and how they are to be collected.

830. FITZPATRICK, L. **How do you feel about . . . working nights?** *Canadian Nurse*, Ottawa, 1977, Sept., vol. 73, no. 9, pp. 34-39.

Of 1,175 nurses questioned about night duty, 64 per cent said they worked nights because they had to and 12.7 per cent because they preferred to. Those who worked at night because of hospital policy had greater difficulty in adjusting to different

sleeping and eating patterns than those who did so voluntarily, and, as a result, their relationships with patients and colleagues were impaired. Even nurses who preferred night duty had some problems finding time for day-to-day activities and interaction with family and friends suffered: these problems were greatly multiplied amongst those who disliked night duty. Those preferring night duty gave the main advantages as independence and a greater chance for communication with the patients. The possible arrangements of nursing shifts, that is, permanent shift, two shifts, three shift rotation and 12-hour shifts are discussed, together with the period of time a nurse should work any particular type of shift.

831. RAYBOULD, E., editor. **A guide for nurse managers.** Oxford & London, Blackwell, 1977, ix, 225pp. £7.75

This book is intended as a guide for nurse managers at every level. The three areas considered cover: organization and change; personnel; and measurement and control, including manpower planning, costing and budgeting control and research. References are included after each of the 10 sub-sections, and there is also an index.

832. GARDENER, M. G. **The history, philosophy and evaluation of the work of the Joint Board of Clinical Nursing Studies.** *Journal of Advanced Nursing*, Oxford, 1977, Nov., vol. 2, no. 6, pp. 621-632.

The Joint Board of Clinical Studies was established in 1970 to consider and advise on the needs of nurses and midwives for post-certificate clinical training in specialized departments of the hospital service in England and Wales, and to co-ordinate and supervise the courses provided as a result of such advice. Later these terms of reference were widened to include community services. The belief that ongoing clinical education should contribute to the quality of patient care, and to the personal and professional development of nurse and midwife, has been fundamental to the formation of the Board's policies. Factual information is given on various aspects of the work of the Board. The difficulty of assessing the value of the work is recognized, but the importance of this activity is stressed. Formative evaluation is required as an integral part of every course. An attempt is made to assess the value of the Board's work to the patients, to the nurses taking the courses, and to the nursing service.

833. DAVIES, M. J. **A 6-year survey of community care courses for basic nursing students.** *Journal of Advanced Nursing*, Oxford, 1977, Nov., vol. 2, no. 6, pp. 597-608.

One result of the establishment and development of a new university hospital and medical school in Nottingham has been that the school of nursing has been able to appoint a community care tutor specifically to teach community aspects within the basic general, psychiatric and paediatric nurse training programmes. This paper describes the development of various courses to meet the General Nursing Council for England and Wales syllabus objectives. The community services involved in the programme are identified and their contributions in time and expertise evaluated. Some discussion is included on the complex relationships between theory and practice and the attempts which are being made to include teaching and learning objectives related to the nursing process within the curriculum. Finally, it is hypothesized that

comments from a group of students on their attitude change as a result of the course, and on the value of their new knowledge and skills when they return to hospital, could form the basis of future research.

834. Regards sur l'enseignment des soins infirmiers. **[A look at nursing care teaching.]** *Hospitalier*, Mantes, 1977, Dec., no. 338, pp. 17-36.

This is a series of six articles entitled: 'Better co-operation between the director of nursing and the director of the training school within the context of the nursing service'; 'The function of the director of the school for nursing administrators'; 'Nurse? Teacher? Director?'; 'A point of view on the training of directors of schools of nursing'; 'Who still cares about training schools for nurses?'; 'Caring for man's needs'. Together they form a useful survey of the problems facing the staff of schools for pupil nurses and nursing administrators in France at the present time.

835. MARRINER, A. and CRAIGIE, D. **Job satisfaction and mobility of nursing educators in baccalaureate and higher degree programs in the West.** *Nursing Research*, New York, 1977, Sept./Oct., vol. 26, no. 5, pp. 349-360.

A study amongst nurse educators was undertaken in 13 western states of the United States to establish the importance placed upon job descriptions in relation to job satisfaction when applying for new posts. A tri-partite postal questionnaire was sent to 1,252 (839 responded) nurse educators of all grades. The first part of the questionnaire dealt with demographic variables; in the second the respondents were asked to rate factors in job descriptions to job satisfaction. The final section consisted of open-ended questions about how nurse educators learnt about new posts. Data analysis of the questionnaires was performed by computer. The results indicate that factors such as geographical location, salary, responsibility, opportunities for achievement and academic freedom were rated highly. The most frequent way of learning about new posts appeared to be through personal contacts.

836. WEBBER, D. L. and MALLEY, P. **Behavioral programmes and patient management for first year nursing students.** *International Journal of Nursing Studies*, Oxford, 1978, vol. 15, no. 1, pp. 31-36.

This is a study to investigate the extent to which the behavioural sciences have been introduced into schools of nursing in a region in Australia. In particular it focusses upon the involvement of first-year students in patient management whilst being introduced to ward work. A programme was devised, and supervised by a senior psychologist and nurse tutor, which included an introduction to behavioural management techniques and their use in patient care; a patient survey by participating students to observe behaviour problems affecting nursing care; and participation in case studies. The programme proved to be an excellent motivational and teaching device and the patient survey showed how greatly patient behavioural problems can affect nursing care.

837. EVERS, H. K. **The patient care team in the hospital ward: the place of the nursing student.** *Journal of Advanced Nursing*, Oxford, 1977, Nov., vol. 2, no. 6, pp. 589-596.

A study amongst the 46 nursing staff of three wards of different specialties found

that the majority of trained staff did see themselves as having regular working links with other health care professionals, specifically doctors, physiotherapists and social workers. Only a tiny minority of the 31 students and nursing auxiliaries felt that they had any working links with other health professionals. Most students believed that for the sake of good patient care and effective learning, they should be part of a multidisciplinary team rather than an exclusively nursing one. Whilst the ward manager can do much to foster the development of a multidisciplinary perspective, it is suggested that structuring the work flow along the lines of patient-centred, rather than task-centred, allocation automatically builds in face-to-face interactions between nurses of all levels and other health professionals. This facilitates the development of mutual role knowledge and effective integrated team working. The ward manager is in the best position to initiate change in work organization, but, if she is to succeed in this complex endeavour, the active co-operation of others is imperative; in particular, medical staff, nursing management and schools of nursing.

838. JOHNSON, M. L. **Nursing auxiliaries and nurse professionalisation.** *Nursing Times*, London, 1978, Feb. 23, vol. 74, no. 8, pp. 313-317.

In a discussion of the relationship between nursing auxiliaries and the nursing profession, it is suggested that qualified nurses, in seeking greater professional recognition through unity, autonomy, a less feminine image and a demand for a more technical basis to nursing, are creating a widening rift between those who control nursing and patient care, and those who give the nursing care. This in turn means that the nursing auxiliary is becoming increasingly involved in direct patient care and is becoming more frustrated and dissatisfied with her role in a nursing world which is pre-occupied with education, management and research, when the skills and understanding of the nursing auxiliary have only been acquired through experience.

839. CLARKE, M. **Planning nursing care: recent past, present and future.** *Nursing Times*, London, 1978, Feb. 16, vol. 74, no. 7, occasional papers, pp. 17-20.

An examination of the literature shows that the nursing care plan is a new development in nursing in the United Kingdom. A number of reasons for this are presented: the present structure of nursing; lack of sufficiently educated recruits to nursing; and the fact that nursing is predominantly a female profession. Although there has been a greater volume of literature concerning the broader concept of the nursing process recently, it is thought that there is substantial resistance within the profession to the concept, even though it can be shown that the planning of nursing care can be of considerable benefit. Finally the author feels that if nurses organize their work in this manner in the future they would be much closer to a professional definition of nursing.

840. STEWART, M. **Integration between physiotherapy and nursing.** *Newsletter, Demonstration Centres in Rehabilitation*, Middlesbrough, 1978, Jan., no. 11, pp. 3-6.

The Report of a Joint Working Party of the Remedial and Nursing Professions aims to further the integration of nursing and the remedial professions, as recommended by the McMillan report of 1973. From experience at King's College Hospital, the author points out that the integration of nursing and physiotherapy courses is

difficult, owing to the differing lengths of the courses and the differing dates of intake of new students. It is possible, however, for qualified staff to lecture to other disciplines: physiotherapists at King's teach 'lifting and handling' to all the introductory schools of nursing in the form of lecture demonstrations. Post-basic training in nursing is funded centrally, but in the remedial professions, shared training puts a great strain on the staff. King's College Hospital, as a demonstration centre, could make a valuable contribution to integrated training if funds were made available for a physiotherapy tutor.

OTHER PROFESSIONAL AND TECHNICAL STAFF

841. BROUN, G. B. L'ingénieur biomédical dans l'hôpital d'aujourd'hui et de demain. **[The biomedical engineer in the hospital of today and tomorrow.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, Jan., vol. 33, no. 388, pp. 67-71; summaries in English, Italian and Spanish, p. 71.

Medical equipment accounts for up to 40 per cent of the cost of a large modern hospital, and the installation, supervision, and maintenance of this equipment require the service of a full-time specialist, the biomedical engineer, who, in turn, requires the support of a team of technicians. The engineer must understand the requirements of the medical staff and the limitations imposed on the administrators, particularly where the purchase of new equipment is concerned, and he must encourage dialogue between these two sides. His training should include some on-the-job experience as well as specialist training at university level. A specialist course exists at the University of Compiegne, and the author suggests that further courses should be initiated.

ANCILLARY STAFF

842. MAGAZINE, M. J. **Scheduling a patient transportation service in a hospital.** *Infor*, 1977, June, vol. 15, no. 2, pp. 242-254.

A patient transportation service is an ancillary service organized for the purpose of moving patients from one site to another, as the need arises, during their stay in hospital. The problem of determining staff patterns and the use of quantitative techniques is discussed with reference to the system in operation at the North Carolina Memorial Hall, Chapel Hill, North Carolina. Methods of simulating the problem and of integrating day-off schedules into the scheme are discussed.

843. LEWIS, E. **Setting up a programme for the forgotten army.** *Health and Social Service Journal*, London, 1978, Jan. 13, vol. 88, no. 4574, pp. 41-42.

A failure to put recommendations into practice has resulted in a lack of training schemes for hospital porters. In Wales, a training scheme devised by the Mid-Glamorgan Health Authority consisted initially of two one-week courses at Prince Charles Hospital, Merthyr Tydfil, covering such subjects as lifting and handling, emergency resuscitation and industrial relations. Course assessment questionnaires distributed to the participants revealed that the course was judged to be successful in making porters feel part of the health care team. A further course was held for head and deputy head porters with the ultimate aim of helping them to organize their own in-service training. If porters who attend training courses discuss them with

their colleagues, the reluctance of some porters to participate in training may be overcome.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 799, 811

844. SPENCER, T. E. **Sharing the load.** *Hospital Forum*, San Francisco, 1977, Sept./Oct., vol. 20, no. 3, pp. 8, 10, 26.

The New Mexico Hospital Consortium provides a variety of services to 11 member hospitals throughout New Mexico with the aim of containing costs. The Consortium is governed by a board of directors who employ an executive director responsible for planning and directing the services offered. Member hospitals pay fees according to their size and the number of services provided. One of the major tasks of the Consortium is to provide continuing education to staff in rural hospitals by providing educational material and instructors for individual hospitals. Since December 1976, 26 sessions have been held in seven hospitals. The Consortium also reduces costs for member hospitals by arranging group purchasing, medical equipment maintenance and staff exchanges.

845. OMNES, M. and others. Le contrôle de gestion et l'entreprise hôpital. **[Management control and the hospital enterprise.]** *Revue Hospitalière*, Paris, 1978, Jan., vol. 42, no. 307, i, pp. 53, 55, 57-95.

Management control is a business concept and in many ways the modern hospital resembles a business enterprise. The report of the working party on this subject describes the principles and methods of management control and examines its present and future applications in the hospital.

846. STOLP, J. Administrativ utvikling og effektivisering i sykehus: fylkeskommunens ansvar. **[Local authority responsibility for administrative development and improved efficiency in the hospital service.]** *Norsk Sykehusidende*, Oslo, 1977, Dec., vol. 50, no. 12, pp. 262-266.

In Norway some 60 per cent of county councils' expenditure goes on health services. The existing health services structure in many ways inhibits collaboration and co-ordination. Primary health services are the responsibility of the Department of Health; county councils run hospitals, nursing homes and the health nurses' service; while municipalities are responsible for home nursing and other non-institutional care. If proper use is to be made of acute hospital beds there must be proper co-ordination between primary care, hospital care, long-stay nursing homes and old people's homes. Co-ordination should be a county council responsibility and this paper gives examples of the ways this could work.

GOVERNING BODIES, COMMITTEES

847. WEEKS, L. E., editor. **Education of a hospital trustee: changing roles for changing times.** Battle Creek, Mich., W. K. Kellogg Foundation, 1977, 155pp.

This report is concerned with the state of the art of health care trustee education

in the United States. The presentations and discussions of the National International Forum on Trustee Education, held at Memphis, Tennessee, from 2-4 November, 1976, jointly sponsored by the South Carolina and Tennessee Hospital Associations, the American Hospital Association, the University of Minnesota and the W. K. Kellogg Foundation are reported. Aspects considered include: the duties and needs of hospital trusteeship; the objectives for trustee education and future directions; and the educational schemes and sources of materials available. A list of participants at the conference is included.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 812, 869, 872-873

848. GODSEY, B. B. **Big savings from simple measures.** *Hospital Progress*, St. Louis, 1977, Dec., vol. 58, no. 12, pp. 39-40.

Mercy Hospital, Charlotte, N.C., recently launched a load and energy management project, working closely with local energy specialists. As a result it expects to save $40,000 next year. The measures, all of which have been implemented with a minimum of expense and physical alterations and without adverse effects on patients or patient care, include: monitoring peak consumption of electricity; modifying the air-handling system; measuring evaporation from cooling towers to obtain a reduction in sewage charges; using equipment timers; and reducing lighting.

849. GREINER, P. C. **The most comfort for the fewest BTUs.** *Hospital Progress*, St. Louis, 1977, Dec., vol. 58, no. 12, pp. 71-73.

Since heating, ventilation and air-conditioning use 40 to 65 per cent of the energy a hospital consumes, they should be the first targets of a power conservation programme. Apart from designing a hospital to reduce heat gains and losses, the principal means of achieving economies is by reclaiming exhaust air and putting it to good use. The means of doing this include: heat wheels; the runaround system; air-to-air heat exchanges; and heat pipes. Other tips for energy conservation cover air-conditioning, lighting, food preparation, water heating and space heating.

850. WATT, E. **Lengthy look at way forward for nursing.** *Health and Social Service Journal*, London, 1978, Feb. 10, vol. 88, no. 4578, pp. 160-162.

This is a description and critique of 'The management of 120-bed clinical nursing units' (see Hospital Abstracts vol. 18, no. 747), an account of research carried out in the five years 1970-1974 in the Wessex Region. The work was commissioned by the Dept. of Health and the Wessex RHA and the programme was designed to establish practical solutions to the problems of managing large nursing units.

851. GRIFFITH, J. R. and CHERNOW, R. A. **Cost effective acute care facilities planning in Michigan.** *Inquiry*, Chicago, 1977, Sept., vol. 14, no. 3, pp. 229-239.

Proposals have been made to reduce the amount of hospital in-patient care in Michigan by 13 per cent. While not drastic, the resulting reduction in beds would be difficult to accomplish. Three distinct arguments can be made for reducing the use

of in-patient care: health, technology and cost. The first part of this paper explores the justification underlying the first two arguments. The second part discusses the recommended occupancy guidelines of the Bureau of Hospital Administration at the University of Michigan School of Public Health, with particular reference to adult medical and surgical services, the largest component of hospital care. The paper concludes by predicting the likely impact on hospitals, doctors and patients if the Michigan bed need proposal were to be implemented in full. The obvious disadvantage of the proposal is that it would create a substantial disruption in the normal pattern of life in hospitals and doctors to which one would only expect slow accommodation. On the other hand, it would improve efficiency (providing care to the same number of people with substantially fewer beds), eliminate much construction, and slow the steady increase of hospital costs by a noticeable amount.

RUNNING COSTS

852. NORTHERN IRELAND. DEPARTMENT OF HEALTH AND SOCIAL SERVICES. **Analyses of running costs, related income and statistics of hospitals and other residential facilities administered by the Health and Social Services Boards, year ended 31 March 1976.** Belfast, Her Majesty's Stationery Office, 1977, 125pp. £3.00

These Analyses of costs prepared from unaudited figures include the running costs, related income and statistics of hospitals and other residential facilities in the health and personal social services. They are designed to facilitate comparisons between similar facilities in Northern Ireland and may be useful for comparisons with Great Britain. Part one of the Analyses shows hospital running costs separately under departmental headings and groups under two main headings 'Direct treatment and ancillary departments' and 'Service departments'. Part two shows the running costs of other residential facilities separately under departmental headings. It provides similar costing information to that shown in part one, except under the accounting system, headings are not required to be costed when annual expenditure is less than £500. An index to facilities is included.

853. DEBACKERE, R., DELESIE, L. and DERIDDER, J. Evaluatie kostprijs algemene ziekenhuizen. Een relaas binnen de Belgische context. **[Evaluation cost of general hospitals. An account of the Belgian situation.]** *Acta Hospitalia*, Louvain, 1977, vol. 17, no. 3, pp. 248-269.

The paper is a report on an investigation into the cost calculations in Belgian hospitals, requested by the Minister of Health in 1976. There is a discussion of: (i) the aims of the study, which are to achieve an 'evaluation' of costs between general hospitals by calculating costs and data in such a way that they can be compared; (ii) methods of procedure, including econometric research before and during the investigation, the concept of a macro study to point out factors which affect costs in general and of a micro study which deals with individual hospitals, legislation towards standardization in Belgian hospitals and a breakdown of the study into four functional groups, viz. housing and finance, logistics, administration, medical and nursing services; (iii) results, including findings on staff legislation, working hours,

wage costs, total hospital costs, services, administration, age of buildings; (iv) conclusions including a suggestion for setting up a basic frame of cost references for Belgian hospitals, quantification of management problems in general and for individual hospitals, comments on structural and active factors affecting hospital costs, need for rationalization in planning and accounting. A dialogue between authorities, hospitals and research workers is recommended. The study examined 12 hospitals with the exclusion of polyclinics and medical support facilities. Summaries are given in French and English.

854. VAN AERT, J. H. and others. Kostenstructuur van algemene ziekenhuizen in Nederland. **[Cost structure of general hospitals in the Netherlands.]** *Acta Hospitalia*, Louvain, 1977, vol. 17, no. 3, pp. 221-247.

An investigation was carried out into the causes of the substantial differences in running costs found between different hospitals. Research concentrated on: (i) whether cost models could be developed for comparing and evaluating cost differences; (ii) to what extent function and size of hospital affect its costs; (iii) how hospital costs are affected by capacity utilization and other variables. There is a description of: the organization of the investigation; the forming of hypotheses; working method; cost models; sources of data. There are some important conclusions concerning the cost structure of general hospitals, including an evaluation of the influence of such specific factors as: specialization; type of patient and their length of stay; availability of medical training facilities especially for specialists; polyclinics; general facilities and services; bed occupation and utilization; age of buildings; administration of both public and private hospitals; admissions; geographical position; and function of hospital. Further research is being carried out. The paper includes four tables, four diagrams and summaries in French and English.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 851, 866, 912-913, 923, 930

855. GLASS, R. I. and others. **The 4 score: an index for predicting a patient's non-medical hospital days.** *American Journal of Public Health*, Washington, 1977, Aug., vol. 67, no. 8, pp. 751-755.

Three hundred and sixty-three patients representing two groups of consecutive medical admissions to a large city hospital were evaluated on admission to determine what factors might predict a 'non medical' or social stay. A follow-up determined when patients were ready for discharge and when the social stay began. A composite index determined the indicator of risk, and 18 per cent of the total in-patient hospital days of this group of patients were attributed to social stay. Fifty six patients had on average a social stay of a week, while 307 patients had a social stay of one day.

856. SCHNEER, E. C. and FIELDING, J. E. **Quantifying the need for hospital beds.** *New England Journal of Medicine*, Boston, 1977, Nov. 10, vol. 297, no. 19, pp. 1065-1068.

The Massachusetts Public Council found that decision making under determination of need legislation was hampered by the absence of accepted standards for determining

the capacity of and the need for the proposed services. In January 1975 it created a task force to recommend such standards. When the task force commenced its task, Massachusetts had 4.6 beds per 1,000 population which it agreed was too many. The task force set a total target figure for 1985 of 3.4 beds per 1,000 population. It also developed a formula to determine how many hospitals beds are required for each health systems agency region and a formula to determine how many hospital beds by specific service are needed for each hospital in a region, on the basis of past patterns of use by town. Another section of the standards and criteria encourages hospitals to become part of a multi-institutional system.

857. FINLAND, M. and BARNES, M. W. **Duration of hospitalization for acute bacterial meningitis at Boston City Hospital during 12 selected years, 1935-1972.** *American Journal of the Medical Sciences*, Thorofare, N.J., 1977, July/Aug., vol. 274, no. 1, pp. 4-12.

An analysis of the length of stay of patients with acute bacterial (purulent) meningitis in Boston City Hospital between 1935 and 1972 revealed considerable differences. Most of the deaths occurred within the first few days after admission or after the diagnosis was first established, but even among fatal cases, the survival time differed depending on the aetiology and site of acquisition of the infection. During the years after effective antibiotics became available the stay of patients with meningococcal, influenzal or pneumococcal meningitis and who survived after admission was shorter then before. However the same is not true for meningitis caused by other gram-positive cocci, gram-negative rods or mixed infections, probably reflecting the relative ineffectiveness of antimicrobial therapy in such patients.

APPOINTMENT SYSTEMS, WAITING LISTS

See Abstract No. 929

OFFICE MANAGEMENT AND METHODS

See Abstract No. 829

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 862-864, 876, 938

858. MAHAJAN, V. and SCHOEMAN, M. E. F. **The use of computers in hospitals: an analysis of adopters and nonadopters.** *Interfaces*, Providence, 1977, May, vol. 7, no. 3, pp. 95-107.

The introduction of the computer and information management techniques has been considered by many to be a possible solution to some of the major management problems currently facing hospitals. Nevertheless, only 40 per cent of the non-federal hospitals in the United States were using computers in 1970. The reasons why some hospitals have adopted computer use and others have not are discussed, and data is used from Texas to support a basic hypothesis. Characteristic profiles of adopters

and nonadopters are developed. The implications of these results both for those concerned with hospital administration and those concerned with the implementation of computer technology are discussed.

859. BEER GABEL, J. Plans régionaux de développement de l'informatique hospitalière. **[Regional planning in the development of hospital computers.]** *Gestions Hospitalières*, Mantes, 1977, Nov., no. 170, pp. 839-844.

The use of computers as a management tool is now firmly established in the French public hospital system and there is a network of regional hospital computer centres. Between 1971 and 1975 the number of hospital beds 'processed' by computer rose at a rate of 10 per cent per annum; between 1971 and 1974 the cost of the hospital computer network rose at a rate of 33 per cent per annum. Computer programs such as GRAPH, SIGMA, GEMCO, and PACHA are now operational in most centres. The author suggests that the time has come to establish regional plans for the future development of hospital informatics. Policy should be decided by regional informatics committees. He presents a theoretical example of a three-year plan, summarized in table form.

860. SIGELLE, R. Un système informatique d'assistance au compte rendu radiologique. **[A computerized system used in a diagnostic X-ray department.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, Jan., vol. 33, no. 388, pp. 98-100.

The author describes the SACRE computer system which allows the radiologist to compile his report on an X-ray film while seated at the computer control desk. Using a special pen, he can mark his comments on a specially prepared board projected onto the screen in the same order as he would when dictating to a secretary. The comments are then printed on the television screen beside the control desk and, if they require no amendments, are stored in the computer memory together with the patient's identification code. The system will also show on the screen a list of diagnoses compatible with the type of lesion on the X-ray film. As well as speeding up preparation of the report, the system can use the report as a basis for invoicing, appointment programs, research, and teaching. The description includes five illustrations.

LIBRARIES

See Abstract No. 804

MEDICAL RECORDS

See also Abstract No. 877

861. FROOM, J. **An integrated medical record and data system for primary care. Part 6: A decade of problem-oriented medical records: a reassessment.** *Journal of Family Practice*, New York, 1977, Oct., vol. 5, no. 4, pp. 627-630.

The Problem-Oriented Record (POR) has gained wide acceptance in American and Canadian medical schools and hospitals over the last ten years. It consists of

four basic components: (i) the defined data base of patient details; (ii) a list of the patient's problems, formulated from the data base and kept up-to-date; (iii) plans for treatment of each problem; and (iv) progress notes. A computerized problem-orientated medical information system (PROMIS) is currently being developed. One of the most profound effects of POR has been its impact on disease classification. The popularity of POR supports the view that it permits an improved quality of patient care by providing a more efficient and logical medical record.

862. VUORI, H. **Privacy, confidentiality and automated health information system.** *Journal of Medical Ethics*, London, 1977, Dec , vol. 3, no. 4, pp. 174-178.

The discussion on privacy seems to be plagued by three fallacies: (i) that the possibility of violating an individual's privacy is a new problem; (ii) the privacy problem is almost exclusively related to, and perhaps even created by, the increasing use of computers; and (iii) the problems and their solutions are largely technological. Although more and more information is required, the hardware of the computer systems is so sophisticated that it would be very expensive to 'break in' and steal from a modern data bank. Those concerned with programming computers are becoming more aware of their responsibilities concerning confidentiality and privacy, to the extent that a legal code of ethics for programmers is being formulated. They are also aware that the most sensitive of all relationships—the doctor-patient relationship—could be in danger if they failed to maintain high standards of integrity. An area of danger is where administrative boundaries between systems must be crossed. Protection of privacy must be ensured by releasing full information about the type of data being stored, and by maintaining democratic control over the establishment of information systems.

863. BRAUNSTEIN, M. L., SCHUMAN, S. H. and CURRY, H. B. **An on-line clinical information system in family practice.** *Journal of Family Practice*, New York, 1977, Oct., vol. 5, no. 4, pp. 617-625.

An on-line clinical information system is in operation within the area covered by the Department of Family Practice at the Medical University of South Carolina in Charleston. Key data are kept for long-term use, and 70 per cent of new diagnoses are coded by the computer as they arise. Four types of printouts are described which make up an important part of the output of the system. These are: (i) periodic morbidity analysis; (ii) individual disease statistics; (iii) disease comparisons among years of residency; and (iv) disease distribution by age and sex. Examples of the printouts are given. An information system which allows such flexibility in the presentation of data greatly assists the clinical, teaching and research purposes of a family practice, particularly as any of the possible analyses can be produced within 24 hours of request.

864. VAQUE, J. El proyecto de informática de la Ciudad Sanitaria de la Seguridad Social de Barcelona. **[The computerized information project of the Health City for Social Security of Barcelona.]** *Estudios sobre Hospitales*, Barcelona, 1977, nos. 85/86, pp. 31-46.

'Health City' in Barcelona has 2,308 beds and a staff of 5,599. A Univac 1106 was installed in 1974 to be used for a patient admissions system, the recording of medical

data, and the mechanization of a series of administrative processes; the software used is DMS-1100 and COBOL ASC11, as well as TIP/CMS and RPS which are used specifically for transactions. The data base consists of 12 areas and 26 different types of register, divided into (a) the master file, (b) the active file, and (c) a collection of tables and indices which includes the Table of Diagnoses in which 7,816 diagnoses and 1,703 synonyms are listed. The system has been gradually extended and now deals with staff, accounts, and medical statistics. A blood donor file and a stocks and purchases file are in preparation.

865. FRISK, P. A., COOPER, J. W. and CAMPBELL, N. A. **Patient medication profiles—evolution, utility and necessity.** *Pharmaceutical Journal*, London, 1977, Dec. 10, vol. 219, no. 5949, pp. 527-528.

This paper reviews the development, use and need for the patient medication profile, or record of information relating to a patient's drug therapy. Also included are the statement on patient medication profiles of the Academy of Pharmacy Practice of the American Pharmaceutical Association and a list of 44 references to the literature.

HOSPITAL STATISTICS

See also Abstract Nos. 934, 946

866. WEST, R. J. **Determination of specialty catchment areas using HAA.** *Hospital and Health Services Review*, London, 1978, Jan., vol. 74, no. 1, pp. 10-12.

Hospital Activity Analysis enables the number of cases admitted to any specialty from any locality to be studied. Then the catchment area of any one district in any particular specialty can be defined as that area in which more patients are treated in hospitals within that district than elsewhere. It is also necessary to examine the proportion of all cases in each locality which are treated in that health district. In this way, differences in the provision of specialties become apparent. If the areas of residence used in the Hospital Activity Analysis were more suited to the type of study described, it would be possible, by the use of a computer, to produce catchment maps for any specialty, diagnosis and age group. These could help determine the optimum location for new services.

PUBLIC RELATIONS

See also Abstract No. 892

867. LASSERRE, J. M. Les relations publiques à l'hôpital. **[Public relations in the hospital.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, Jan., vol. 33, no. 388, pp. 131-132, 135.

The author believes that every hospital should have a public relations (PR) department to improve the hospital's public image and attract more patients, to create a climate of confidence within the hospital, and to lead to better integration of the hospital within the community. No new posts would have to be created as PR functions could be assigned to one member of the administrative staff. The main objectives

would be the dissemination of information to the public within the hospital (patients, medical staff, and paramedical staff) and outside it. The author outlines the organization and structure of a PR department and suggests that the person responsible for this department should receive specific training for the job.

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract No. 824

868. WOOD, C., editor. **The influence of litigation on medical practice: proceedings of a conference sponsored jointly by the Royal Society of Medicine and the Royal Society of Medicine Foundation Inc. held at 1 Wimpole Street, London, 16-18 May, 1977.** London, Academic Press, [ix], 215pp. £10.20

This book contains the views of 20 distinguished speakers from the fields of medicine, law and insurance from both sides of the Atlantic who discuss the current position in the United States and United Kingdom in the approach to litigation for medical practice. Aspects considered include: history, development and current position in the U.S.A. and U.K.; major current problems as seen by lawyers, doctors and insurers; high risk clinical areas; education and training; the lawyer as representative of the patient; and proposals for the future in the United Kingdom and United States.

FINANCE AND ACCOUNTING

FINANCE

See also Abstract Nos. 813, 886, 901, 903

869. **Improving profitability.** *Topics in Health Care Financing*, Germantown, 1977, vol. 4, no. 1, pp. 1-111.

While the pursuit of profitability should not be the sole or even primary objective of a health care facility, the attainment of some positive level of profit should be a legitimate objective for most of them. Most facilities have an urgent need for profit for the replacement of capital assets and to meet the accelerated rates of current inflation and technological change. The seven papers in this issue are devoted to the improvement of profitability and cover: an overview of profitability in the health care industry; reimbursement management; optimal depreciation methods for reimbursement; relationships with intermediaries; unrelated taxable business income; accelerating philanthropic giving; and investment income.

870. SIMON, J.-M. and others. Le cout de la santé et les hôpitaux: un essai d'evaluation comparée. **[Health costs and hospitals: evaluation and comparison.]** *Revue Hospitalière*, Paris, 1978, Jan., vol. 42, no. 307, i, pp. 7, 9, 11-46.

A comparison of statistical data (in nine tables) shows that the average expenditure on health in nine countries (Italy, Great Britain, France, West Germany, Belgium, Holland, Sweden, the U.S.A., and Canada) was 6.5 per cent of Gross National

Product and for France the figure is 6.9 per cent. Health costs in all these countries are rising faster than GNP and hospital costs represent an increasing part of these costs (40-45 per cent in France, 55-60 per cent in Italy, Great Britain, and Holland); the reasons for these increases are similar in all these countries. A further series of 18 tables describes the situation in France as to cost distribution, the activity of public and private hospitals, number of beds, number of out-patient consultations, length of stay in hospital, staff costs, and numbers of staff. The introduction of better and more effective health planning and a clearer definition of the role of the hospital are recommended for the future.

871. BAUER, K. G. **Hospital rate setting—this way to salvation?** *Health and Society*, New York, 1977, vol. 55, no. 1, pp. 117-158.

Between 1970 and 1975 the number of rate-setting programmes in the United States grew from two to 27. These programmes, most of which are administered by Blue Cross plans or state governments, now control the rates or charges to one or more major types of payer in 23 states and affect to some degree more than 25 per cent of the nation's acute care hospitals. This paper reviews highlights in the state and regional experience as at 1975. After outlining the nature of rate-setting, it examines some of the major issues that implementation has brought to the fore. In particular it notes the kinds of assumptions on which this new and highly demanding form of regulation was premised, the sometimes contradictory expectations held for it, the strengths and weaknesses of various types of structures for its administration, and certain problems of methodology and information that handicap efforts of rate-setting bodies to accomplish their intended purposes. Finally it deals with the kinds of risks and incentives that rate-setting programmes introduce to hospitals, sometimes by intention, sometimes inadvertently, and often because of the still limited state of the art. It is concluded that experience indicates that in and of itself rate-setting is by no means the way to salvation. Federal policy-makers were wise not to have rushed prematurely into this plausible-sounding route to cost containment.

872. WEINER, S. M. **'Reasonable cost' reimbursement for inpatient hospital services under Medicare and Medicaid: the emergence of public control.** *American Journal of Law and Medicine*, Cambridge, Mass., 1977, vol. 3, no. 1, pp. 1-47.

In 1965 Congress established the Medicare and Medicaid schemes and mandated that hospitals should be reimbursed for the 'reasonable cost' of providing in-patient services to Medicare and Medicaid patients. The interpretation of 'reasonable cost' has been made with excessive liberality and created a fiscally burdensome and inflationary reimbursement system lacking the principles of efficiency and planning. The attempts to reformulate 'reasonable cost' as applied to Medicare and Medicaid have culminated in Public Law 92.603 which introduced the concepts of: (i) tough evaluation of the reasonableness of hospital costs, with emphasis on efficiency, utilization and planning; (ii) shifting *de facto* power over reimbursement rates away from the hospitals and into the hands of the agencies that purchase their services; and (iii) increased public scrutiny of hospital work. The effect of the law is seen as: (i) a healthy balance between the needs of the hospitals and the needs of the

public; (ii) the trend towards cost control and public control has been furthered in those States which have statutorily established hospital budget or charge review schemes; and (iii) any such trend will continue and affect any future national health insurance plan.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

873. WEISMAN, P. C. and TARBUTTON, D. W. **Hospitals work with commission to ensure equitable costs.** *Hospitals*, Chicago, 1977, Nov. 16, vol. 51, no. 22, pp. 81-85.

All hospitals in Washington State are required to submit proposed budgets and daily service costs to the Washington State Hospital Commission. Following a review of the Commission's accounting and reporting requirements, the Puget Sound Chapter of the American Society for Hospital Food Service Administrators, decided to conduct an informal survey of catering departmental costs. The project yielded two results: establishment of a permanent research and development committee, which continues to gather quarterly data; and a modification to the method of determining and allocating food service costs which was made and accepted by the Commission. Some of the data produced are presented in tables and discussed: patient costs, non-patient costs, and productivity indicators.

874. KAUD, F. A. **Operating budgets are valuable in managing finances.** *Hospitals*, Chicago, 1977, Nov. 16, vol. 51, no. 22, pp. 69-70, 72-73.

The operating budget is one of three budgets used by a hospital's administrator; the others are the cash and capital outlay budgets. It consists of a statistical analysis, a listing of expense statements, and a statement of operating revenues. The annual food service budget should start off with the total number of patient days and clinic visits (representing the level of the volume of patient activity). Next, total meals served by a food service department are distributed into patient and non-patient areas. The operating expense part of the budget will include food, labour, supplies and other costs. It is recommended that the food service performance report be used as a source document. Detailed accounts of expenses are provided in supplementary schedules.

DIETETICS IN THE HOSPITAL

875. HUNT, E. G. **Rhode Island builds a career ladder in dietetics.** *Journal of the American Dietetic Association*, Chicago, 1977, Dec., vol. 71, no. 6, pp. 635-638.

In Rhode Island, new initiatives in dietetic education have resulted in a career ladder in this vital field. A course for dietetic assistants, providing both theoretical and practical aspects of training, was started at Rhode Island Junior College in 1975. Seventy-eight people have now completed it and 25 more are currently enrolled. A course for dietetic technicians, emphasizing nutritional care, is now being planned,

following a survey in the Island to ascertain employment opportunities, which appeared to be good. In addition to these two courses, the University of Rhode Island is attempting to establish a four-year undergraduate course in dietetics, thereby shortening the time required to become a registered dietitian.

LAUNDRIES AND LINEN SERVICE

LAUNDRIES

876. St. Clair, N. L. and others. **Computer provides definite linen distribution and control mechanism.** *Hospitals*, Chicago, 1977, Nov. 16, vol. 51, no. 22, pp. 95-96, 101, 103.

For the past 10 years or so, large laundries have been concerned with productivity. While productivity has increased by 10 to 20 per cent, the linen replacement cost in these same laundries has more than doubled. It will not suffice for these laundries to point towards the hospitals they serve and imply that linen service and control is solely a hospital management problem. As long as proven technology is available, these laundries have an inherent responsibility to provide hospital management with the data necessary to pinpoint and correct linen consumption and replacement problems. A computer-based information system can provide this data; a number of features of such a system are discussed.

HYGIENE IN THE HOSPITAL

HOSPITAL INFECTIONS

877. Hovig, B. Registrering av sykehusinfeksjoner. **[Recording of hospital infections.]** *Sykehuset*, Oslo, 1977, vol. 40, no. 6, pp. 321-327.

A distinction is drawn between records of hospital infections based on incidence studies (carried out continuously over a period) and prevalence studies (of infections at a particular time). A pilot incidence study of post-operative infections in the surgical department of the Rikshospital, Oslo, during a 2½ months' period in 1975-76 showed that 95 (or 24 per cent) of 411 patients had hospital infections. This percentage was made up as follows: wound infections, eight per cent; urinary tract infections, five per cent; other infections, three per cent. Since January 1975 the Rikshospital has been making a computer analysis of the results of bacteriological tests. The type of test material is recorded in 31 categories under seven main heads and 49 types of micro-organisms are recorded under seven main heads. The figures for 1975 for the whole hospital are as follows: total number if isolated, 4640 of whom 3088 were positive, (16 per cent upper respiratory tract, 8 per cent lower respiratory tract, 43 per cent urinary tract, 20 per cent skin, 7 per cent blood, 6 per cent others). Gram-positive cocci represented 36 per cent and Gram-negative bacilli 63 per cent.

878. HOFFMAN, P. C. and DIXON, R. E. **Control of influenza in the hospital.** *Annals of Internal Medicine*, Philadelphia, 1977, Dec., vol. 87, no. 6, pp. 725-728.

Hospital transmission of influenza has been reported infrequently; however, patients in general hospitals are often among the most susceptible to the complications of influenza infection. Hospital-acquired influenza may occur more often than is reported, but it may not be recognized because of lack of diagnostic facilities or the time required for virus isolation and identification. Based on the mode of transmission in the hospital, the established reservoirs of influenza virus and duration of virus shedding, isolating patients with influenza may occasionally be useful, but restricting visitors is probably not required. Vaccinating staff with influenza vaccine and, if influenza A is prevalent, giving amantadine hydrochloride to high-risk patients or staff should both be considered.

879. SAIFEE, I. A., GAJERA, G. K. and GODBOLE, V. K. **Incidence of hospital staphylococci and their antibiotic sensitivity pattern.** *Journal of the Indian Medical Association*, Calcutta, 1977, June 1, vol. 68, no. 11, pp. 227-229.

Nasal and nail swabs were collected from 200 members of the hospital staff at the New Civil Hospital, Surat, Gujarat, to investigate the carrier rate of staphylococci and their antibiotic sensitivity pattern. Staphylococci were isolated in 139 cases, giving an average carrier rate of 65.2 per cent in doctors and 73.1 per cent in nurses. A large percentage of the strains were resistant to penicillin and streptomycin, and 51 per cent displayed multiple resistance. The danger of staff infecting patients can be minimized by the topical application of suitable drugs.

880. DIGRANES, A. Sykehusinfeksjonenes mikrobiologi og epidemiologi. **[Microbiology and epidemiology of hospital infections.]** *Sykehuset*, Oslo, 1977, vol. 40, no. 6, pp. 315-321.

A general account of hospital infections—defined as infections which strike patients in hospitals and which arise during a hospital stay—is given under the following heads: infective material; sources of infection (auto-infection and cross infection); resistance to infection; and surveillance of hospital infections. No reliable figures exist on the incidence of these infections in Norway but there is no reason to suppose that it differs from the five per cent to 15 per cent recorded in England and the United States. An analysis of 2,400 isolations from surgical in-patients at the Hangeland Hospital, Bergen, in 1974-75 shows that 53 per cent were Gram-negative bacilli (mainly *Escherichia coli* but also *Klebsiella* and *Proteus mirabilis*); 12 per cent of isolations were of staphyloccocci and there was the same percentage of enterococci. Fifty-two per cent of 1,245 positive bacteriological tests in the same department in 1975 were from urine, 22 per cent from pus and wound secretions and 17 per cent from the lower respiratory tract. The most frequent organisms recovered from wound infections were *E. Coli* (23.8 per cent), coagulase positive staphylococci (22.7 per cent) and other enterobacteria (12.2 per cent).

881. HAMBRAEUS, A. and MALMBORG, A.-S. **Surveillance of hospital infections: at the bedside or at the bacteriological laboratory?** *Scandinavian Journal of Infectious Diseases*, Stockholm, 1977, vol. 9, no. 4, pp. 289-292.

A prevalence study concerning wound infections in the surgical service at Huddinge

Hospital, Sweden, was made during a seven-month period. One ward was visited every week during the wound dressing rounds and samples for bacteriologic culture were taken from clinical infection. The prevalence of infection varied between 0 and 21 per cent for surgical wounds and 0 and 47 per cent for other wounds. A comparison of the number of cultures taken by the investigators and that taken by the ward revealed that the culturing frequency of the ward staff was so high that surveillance of infection by review of bacteriological culture records only, would give an almost equivalent degree of information concerning infection rates. The advantages of the system are that it is less time consuming and can give epidemiological information. The drawback is that little or no patient data are given on the requisitions from the ward which makes it impossible to know from what kind of infections samples are taken.

SOURCES OF INFECTION

See also Abstract Nos. 878-879

882. SIKULER, E. and others. **Hepatitis B antigen and antibody among staff members of an Israeli hospital and a kibbutz population.** *Vox Sanguinis*, Geneva, 1978, Jan., vol. 34, no. 1, pp. 25-31.

A study of the incidence of hepatitis B surface antigen (HBs Ag) and antibody (anti-HBz) among 388 workers at a major medical centre in Israel with 203 kibbutz residents, using radio immunoassay procedures, revealed that of the hospital staff, 1.8 per cent were found to carry the antigen and 23.9 per cent the antibody. In contrast 0.5 per cent of kibbutz staff were antigen-positive and 11.8 per cent carried the antibody. The highest incidence of antibody was found among people born in middle-eastern countries outside Israel. The results revealed that a marked increase in the frequency of sera positive for anti-HBs took place after the first year of hospital work.

883. LINNEMANN, C. C. and others. **Screening hospital patients for hepatitis B surface antigen.** *American Journal of Clinical Pathology*, Philadelphia, 1977, March, vol. 67, no. 3, pp. 257-259.

A survey of 1,026 adult patients (79.5 per cent of all adult patients) admitted to Cincinnati General Hospital in September 1974 showed that 1.5 per cent had hepatitis B surface antigen in the blood and 22 per cent had hepatitis antibody. The majority of patients with hepatitis B did not have clinical hepatitis and would not have been recognized without screening all admissions for hepatitis B antigen. The question of routine screening is discussed in relation to the risk of acquiring hepatitis. Routine screening would not seem to be justified. Routine measurement of serum glutamic oxaloacetic transaminase on admission would be less expensive and more effective in identifying anicteric or chronic hepatitis. An alternative approach to the screening of all admissions for hepatitis antigen would be to identify high-risk sub-populations to be tested.

PREVENTION AND CONTROL

See also Abstract Nos. 880-881, 883, 940

884. BRUUN, J. N. Forebyggelse av urinveisinfeksjoner. **[Prevention of urinary infections.]** *Sykehuset*, Oslo, 1977, vol. 40, no. 6, pp. 329-332.

Most infections of the urinary tract result from catheterization or other urological

procedures or operations. Two preventive measures are important: (i) the use of sterile catheters inserted by an aseptic technique (sterile gloves or sterile tweezers); and (ii) destruction of bacteria in the urethral orifice or in the urethra (use of chlorhexidine or other disinfectant and urethral irrigation). Most infections occur in patients with indwelling catheters: here the most important preventive measure is the maintenance of closed drainage. Daily cleansing and application of antiseptic cream around the point of entry of the catheter is also important. Intermittant irrigation of the bladder prevents stoppage of the catheter. Silver nitrate (0.25 per cent) and chlorhexidine (0.20 per cent) are the best irrigation fluids.

STERILIZATION

See also Abstract No. 900

885. GALTIER, F. Sur le coût de la stérilisation par l'oxyde d'éthylene sous pression et ses conséquences pratiques. **[On the cost of ethylene oxide sterilization under pressure and its practical consequences.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, Jan., vol. 33, no. 388, pp. 79-83.

The author proposes a method for calculating the cost of ethylene oxide sterilization which takes account of depreciation, labour, energy, and ethylene oxide costs, and the cost of checking sterility and the residual ethylene oxide level after desorption. He also discusses the possibilities of: (i) using unit-dose ethylene oxide cartridges; (ii) preconditioning the material before placing it in the sterilizer, thus shortening the cycle and reducing the cost of the operation by 20 per cent; (iii) the use of a sterilizer big enough to allow use for one hour a day and desorption for the other 23; and (iv) recycling of the sterilizing gas.

SAFETY MEASURES

ACCIDENTS, GENERALLY

See Abstract No. 887

PLANNING FOR MASS EMERGENCIES

See also Abstract No. 914

886. CETTOUR-BARON, G. Financement de l'exploitation des services d'aide médicale urgente. **[Financing the running of emergency medical services.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, Jan., vol. 33, no. 388, pp. 126-130.

The official texts relating to the Emergency Medical Aid Services in France (SAMU) do not clearly indicate whether the running costs should benefit from subsidies or aid from the State or public institutions. The author examines the initial

decree (1965) in some detail. He then describes the results of a survey of hospitals designed to discover how these determined charges to the patient for SAMU. The methods used and the amounts charged varied enormously. He argues that the cost of running SAMU 24-hours a day is so high that the State should subsidize this service.

RADIATION HAZARDS

887. SEERAM, E. **Protecting patients from radiation.** *Dimensions in Health Service*, Toronto, 1977, Oct., vol. 54, no. 10, pp. 40-42.

The principles of radiation protection discussed in this article relate to the measures laid down by the International Commission on Radiological Protection. These principles concern: (i) time of exposure; (ii) distance between the patient and the source of radiation; and (iii) the insertion of a shielding material, such as lead. Physical factors are concerned with the filtration and the collimation of the X-ray beam. The introduction of more sophisticated X-ray components, such as the image intensifier tube, has reduced patient dose still further. Protection also depends on good operational practice, such as proper positioning of the patient and the correct choice of exposure settings. Patient protection is currently receiving widespread attention throughout the world.

888. HOSPITAL PHYSICISTS' ASSOCIATION. **Notes for the guidance of radiological protection advisers and radiological safety officers in departments where radio-isotopes are used** (HPA Report Series No. 14) London, Hospital Physicists Association, 1975, 42pp.

This report provides guidance for Radiological Safety Officers and Radiological Protection Advisers in radioisotope procedures in departments using radio-isotopes. Aspects covered include: local rules; records required in radio-isotope departments; laboratory design; monitoring; incidents involving uncontrolled dispersal of radioactive substances; and the protection of the public. Five appendices are included listing; sample local rules; references in the Code of Practice to the duties of the Radiological Protection Advisers; contents of emergency box; amounts constituting a fire hazard; and a select list of references.

THE PATIENT

ADMISSION AND RECEPTION

See also Abstract Nos. 915-916, 927

889. GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **Administrative arrangements: admissions policy - establishing a policy for controlling admissions.** (Notes on Good Practices No. 1, 1977) London, Her Majesty's Stationery Office, 1977, [3]pp. £0.25

An admissions policy for controlling admissions was developed in two new District General Hospitals built by the Wessex Regional Health Authority. The design of the

120-bedded clinical nursing units within these hospitals was influenced by the policy of the Authority that beds would not be allocated to specific consultants, that patients of either sex would be admitted and that a system of progressive patient care would be operated. The methods of approach for emergency admissions and the operating theatre workload is discussed. This method of planning admissions has been used for the past four years, and a significant benefit to patients is that it is now rare for a waiting list admission to be cancelled at the last moment.

WELFARE OF THE PATIENT

See also Abstract Nos. 818, 893, 898, 939, 947

890. HEARN, C. R. and POTTS, D. **The effect of patients' individual characteristics upon activity times for items of nursing care.** *International Journal of Nursing Studies*, Oxford, 1978, vol. 15, no. 1, pp. 23-30.

A description of the analysis of work measurement data to determine the effects of patients' characteristics upon event times is given. This forms part of a larger study to provide a "package" for calculating staffing requirements of the different grades needed to care for geriatric patients based upon individual nursing needs. A variety of different sources were used to collect data for the study from a number of geriatric wards in the West Midlands RHA. The patients' self-care capacity and dependency factors were used to calculate the effect upon the length of time needed to carry out an item of direct nursing care. The authors feel that care categories are a useful predictor of the workload generated by patients and that a graph (illustrated) can be used to assess the number of nursing staff needed on a particular geriatric ward with a particular patient mix.

891. SALMON, G. C. and others. **A patient opinion survey: Wellington Hospital—1974.** (Special Report No. 49) Wellington, N.Z., Department of Health, Management Services and Research Unit, [vii], 124pp.

This report on Wellington Hospital combines the patient view with the hospital response and also brings into question policies of the New Zealand Department of Health. Areas studied include: admission and reception; discharge; the ward; sanitary facilities and cleaning; life in the ward; meals; nursing care; staff/patient communication; and the best and worst in hospital; Chapter 12 reviews the findings of the study in the light of other research and speculates on the future of consumer research in New Zealand hospitals. The appendices include a table showing questionnaire results.

892. SELECT COMMITTEE ON THE PARLIAMENTARY COMMISSIONER FOR ADMINISTRATION. SESSION 1977-78. **First report, together with the proceedings of the committee and part of the minutes of evidence taken in sessions 1975-76, 1976-77, relating to the report: independent review of hospital complaints in the National Health Service.** (H.C.45) London, Her Majesty's Stationery Office, 1977, ii, 239pp. £5.60

This first report considers the field of health service complaints in England, Scotland and Wales, but omits internal procedures, family practitioner services, personnel

matters and mental health review tribunals. The scope of the enquiry and the existing arrangements are outlined. The underlying considerations of the present systems are discussed and various recommendations presented.

THE GENERAL PRACTITIONER AND HIS PATIENTS

See also Abstract No. 823

893. BENNETT, A. E. **Communication between doctors and patients.** London, Oxford University Press, for Nuffield Provincial Hospitals Trust, 1976, 134pp. £3.00

The five papers in this book, together with the commentary, present a brief state-of-the-art review of doctor-patient, patient-professional communication. Although it deals primarily with face-to-face communication, the theme is developed to place this in the wider context of persuasive education and health education. Aspects considered include: an analysis of face-to-face communication; communication of patients' feelings in hospital; training medical students to communicate; towards better doctor-patient communications; and persuasive communication.

TRANSPORT OF PATIENTS

See Abstract Nos. 811, 842

HOSPITAL CARE

See also Abstract Nos. 836-837, 839, 850, 890, 898, 917, 919, 928, 931, 948

894. BLOCH, D. **Criteria, standards, norms—crucial terms in quality assurance.** *Journal of Nursing Administration*, Wakefield, Ma., 1977, Sept., vol. 7, no. 7, pp. 20-30.

With many diverse groups actively seeking ways to evaluate health care, the basic terminology used must be clear and accurate. This paper discusses three crucial terms, criterion, standard and norm, to stimulate thinking and encourage further discussion. It does so by relating the terms to a hypothetical example in the area of radiation exposure and developing a model on an incremental basis.

895. FOSTER, W. and others. **Hospital/community/education nursing audit—a research enterprise.** *Nursing Mirror*, Sutton, 1977, Dec. 8, vol. 145, no. 23, pp. 26-28.

A nursing audit was set up in the South Glamorgan Health Authority Teaching Division to obtain an overall picture of management and practice among all grades of nursing staff. The Area Team approved the audit, which was headed by an Area Nurse. A research team was also established to design a suitable measuring instrument for

standards and a questionnaire appropriate to each grade of nursing staff. The answers to the questionnaires were computerized to provide figures and percentages of each answer to a question. Teams are being set up to take action on problems revealed by the data produced by the audit. Some answers require further analysis before the nature of the problem can be properly understood. As the audit proceeds, certain common problems and their distribution within the area will become clear.

HOME CARE, AFTER-CARE

896. MOORE, F. M. **New issues for in-home services.** *Public Welfare*, Washington, 1977, vol. 35, no. 2, pp. 26-38.

Home care services appear finally to have been recognized as an important part of the health and social services system by a significant group of providers, consumer organizations, third-party payers, federal legislations and administrative agencies. This paper first discusses the definition of home care and traces trends in home care services. Three areas requiring priority attention in setting up a home care system are then discussed: (i) increasing available funds for home care services while decreasing the extreme fragmentation in the federal administration of present resources; (ii) requiring and maintaining reasonable quality assurance and cost control; and (iii) co-ordinating the various home care services and helping the agencies to address common problems.

SPECIAL DEPARTMENTS

WARDS

See also Abstract No. 939

897. SCOTTISH HOME AND HEALTH DEPARTMENT. **In-patient accommodation.** Revised 1977. (Hospital Planning Note No. 1) Edinburgh, Her Majesty's Stationery Office, 1977. £3.90

The aim of this Hospital Planning Note is to provide guidance on the planning and design of in-patient accommodation. The main concern of this note is with the functions which take place and with the essential relationships between the various functions, and with establishing design criteria appropriate to these functions. Aspects considered include: functions of in-patient accommodation; factors affecting design; examination of functions and development of accommodation requirements; design considerations; architectural and engineering aspects; and accommodation and design requirements.

898. STEELE, S. J. and MORTON, D. J. B. **The ward round.** *Lancet*, London, 1978, Jan. 14, vol. i, pp. 85-86.

Ward rounds are often criticized by both patients and staff. If it is conducted without regard for the patient's feelings and dignity, the ward round can be a cause of embar-

rassment and anxiety and can lead to the loss of a patient's confidence in the medical staff. The patient should be made to feel he is part of the round, the staff being introduced and technicalities explained. Discussions should be as inaudible as possible to other patients and examinations should be conducted behind curtains. If the patient is to be the focal point of a teaching round, his permission must be sought. Some doctors and nurses know instinctively how to behave towards patients, but some, especially students, need guidance in their behaviour.

ANAESTHESIA

899. AHNEFELD, F. W., KILIAN, J. and MEHRKENS, H. H. Das Anästhesiegeräte-Pflegezentrum—Möglichkeiten zur methodischen Geräteaufbereitung in der Anästhesie und Intensivmedizin. [**The anaesthesia equipment care centre, provision for the systematic preparation of equipment for anaesthesia and intensive care.**] *Medizinal-Markt Acta Medicotechnica*, München, 1977, Dec., vol. 25, no. 12, pp. 388, 390-392.

The proposal for an anaesthesia equipment centre put forward in this paper aims to provide an organized service for the preparation of anaesthesia apparatus and other equipment for intensive care and to set out guidelines in this area. The centre needs to have an area of 35 to 40 sq. m. and to have clean and dirty sides. The workflow divides into the following operations: dismantling of equipment; cleaning, disinfecting and rinsing; cleaning and disinfection of tubing; drying; mounting and checking; disinfection and sterilization; ventilation of tubing and equipment; replacement of seals; re-assembly; checking; and setting up equipment. Each operation is briefly described. The centre, which should come under the departments of anaesthesia and intensive care, can be used not only for anaesthesia and intensive care equipment but also for atomizers, inhalation apparatus, and infusion pumps for other hospital departments. The paper includes a workflow plan and a sketch plan of a centre serving eight operating centres.

PHARMACY

See also Abstract No. 865

900. GOLDBERG, L. A. and RICHARDSON, K. D. **Development of a new bottle rinse conveyor for use in sterile production units.** *Pharmaceutical Journal*, London, 1977, Nov. 26, vol. 219, no. 5947, p. 481.

The Clinivey bottle rinse conveyor, was developed jointly by engineers and hospital pharmacists to provide a means of transferring washed bottles from an unclean washing area to a clean filling area. The conveyor operates by pneumatic line pressure and bottle sizes from 100ml. to one litre can be rinsed in distilled water at the rate of 360 per hour. The action of the conveyor, which is simple to operate, is described in detail. After use, the machine is left in a perfectly dry state and removable parts are autoclaved.

901. DILLARD, K. R., YOSHIKAWA, T. T. and GUZE, L. B. **Appropriate usage of antibiotics improved by surveillance program.** *Hospitals*, Chicago, 1977, Oct. 1, vol. 51, no. 19, pp. 81-82, 84-85.

Various studies have demonstrated the over-use and misuse of antibiotics in hospitals; their widespread use is one contributory factor in the rising cost of medical care. Following one such study at Harbour General Hospital, Torrance, Calif., a pilot control programme was established. Main features of the programme were; (i) monitoring all requests for antibiotics for adult in-patients; (ii) removal of all antibiotics from ward medicine rooms, except small quantities in operating theatres and delivery rooms; (iii) prescriptions for antibiotics were only honoured if on a special form (reproduced); and (iv) with all antibiotics requests, a two-day (three-day on Friday and Saturday) supply would be automatically dispensed and further supply would depend on vetting by a member of the infectious disease service. The quantity and pattern of antibiotic use was carefully tabulated at three- and six-month intervals. Following this only a select group of antibiotics were included in the monitoring system; they were chosen on the basis of cost, toxicity and newness to the formulary. Savings from the pilot programme and that instituted after six months were both estimated at about $82,000 per year.

LABORATORIES

902. LIZANA, J. A. Organizacion de los laboratorios de bioquimica clinica en Chile. **[Organization of clinical biochemistry laboratories in Chile.]** *Boletin de la Oficina Sanitaria Panamericana*, Washington, 1977, Aug., vol. 83, no. 2, pp. 130-139.

A survey was made of the hospitals in the state health service in order to evaluate the status of health laboratories in Chile. Each institution was sent a questionnaire containing 23 questions on available manpower, instruments, methods used, quality control and proficiency schemes together with the organization and supply of the laboratories. The findings, based on the replies received from the 20 main hospitals and visits to 23 provincial centres and rural areas in Southern Chile, revealed a wide disparity in services, staffing, methods used and supplies. The need to rationalize services and allocate specific functions within laboratories with a view to making better use of the available resources is discussed.

903. RICHARDSON, R. W. **Comparison of cost of preparing reagents in laboratory with cost of using commercial kits.** *Lancet*, London, 1977, Dec. 17, vol. ii, pp. 1273-1275.

This paper attempts to compare the cost of commercially prepared reagents with that of reagents prepared in the laboratory, in relation to certain laboratory tests at different workloads. The cost of reagents in kit form could only be justified for three named enzyme estimations, if the laboratory performed less than about 35 tests a day. It is unlikely that the use of kits for three named hormone estimations can be justified for any workload. In very small laboratories, without suitable staff, the use of kits may be desirable. The author estimates that between £2 million and £3 million is spent unnecessarily by the National Health Service each year to purchase commercially prepared reagents for the six tests studied.

DIAGNOSTIC X-RAY DEPARTMENT

See also Abstract No. 860

904. KIERMAN, B. and ROSENBAUM, H. D. **An evaluation of physician assistants in diagnostic radiology (DHEW Publication No. (HRA) 77-3164)** Hyattsville, Md., National Center for Health Services Research, 1977, iv, 20pp.

This project, supported by the National Center for Health Services Research, demonstrates a method to improve the use of radiology manpower by developing a scheme that would train selected, highly-motivated radiology technicians to assume the responsibility for many of the duties which are at present the sole responsibility of physician radiologists. A two-year training scheme providing on-the-job experience was established to enable radiology technicians to be better equipped to help the physician radiologist in departmental administration, to help in angiographic studies, and to differentiate between normal and abnormal roentgenograms.

905. PLAINFOSSE, M. Ch. and MERCIER-PAGEYRAL, B. L'organisation d'un laboratoire d'échographie. **[The organization of an echography laboratory.]** *Gestions Hospitalières*, Mantes, 1977, Nov., no. 170, pp. 821, 823-829.

This informative account of how ultrasound echography works, and what the different echographic techniques are i.e.: A(amplitude) scan, B(brilliance) scan, and Doppler—is followed by a list of the indications for each technique. Echography is of particular value in obstetrics, as it is non-invasive and provides a great deal of information. The apparatus required—the echograph, probes, examination couch, the media for the ultrasound image—is described and illustrated by four photographs. The location and planning, staffing, and costs of an ultrasound unit are also examined.

RADIOISOTOPE DEPARTMENT

See Abstract No. 888

REHABILITATION

See also Abstract No. 935

906. **Garston Manor rehabiliation centre.** *Newsletter, Demonstration Centres in Rehabilitation*, Middlesbrough, 1978, Jan., no. 11, pp. 14-35.

Garston Manor Rehabilitation Centre, Watford, Herts, was opened as a residential medical rehabilitation centre in 1951. In 1968 a small industrial unit was opened, and renamed an Employment Rehabilitation Centre in 1974. A Functional Assessment Unit has recently been built, incorporating a disabled housewife's flat and an information and exhibition area. Details of the centre as a whole, its patients, the treatment given and plans for the future are given in the introductory article of a series of six. The second article deals with the role of occupational therapy at Garston Manor and the third with physiotherapy and hydrotherapy. The fourth article describes assessment and treatment in speech therapy, and the sixth deals with the remedial gymnastics, a form of treatment particularly valuable in the later stages of recovery. The fifth article

describes the management of rehabilitation services at Garston Manor, including the Employment Rehabilitation Centre. In recent years there has been a decline in the number of orthopaedic cases and an increasing demand for the rehabilitation of patients with medical disabilities.

907. DIERCKS, E. A. Pädagogische Rehabilitationseinrichtungen für erwachsene Hörgeschädigte in Dänemark. **[Pedagogical rehabilitation centres for hearing-impaired adults in Denmark.]** *Rehabilitation*, Stuttgart, 1977, Nov., vol. 16, no. 4, pp. 253-255.

In Denmark when hearing impairment has been diagnosed by a specialist the patient is referred to one of the three hearing centres (Copenhagen, Odense or Aarhus). If in-patient treatment is needed the patient goes to one of the hearing clinics scattered throughout Denmark: he then goes to a hearing centre to have an aid fitted. If, as is often the case, the patient still cannot communicate properly he is referred to a hearing institute (Copenhagen or Fredericia). Here he is trained in the various aspects of speech and hearing: length of stay can vary from 14 days to four months. After discharge he is under the care, at his home, of a hearing assistant who advises both the patient and his family.

PHYSIOTHERAPY DEPARTMENT

See Abstract No. 840

DEPARTMENTS FOR SPECIAL THERAPY

See also Abstract No. 935

908. ISAF, J. J. and ALOGNA, M. T. **Better use of resources equals better health for diabetics.** *American Journal of Nursing*, New York, 1977, Nov., vol. 77, no. 11, pp. 1792-1795.

The development of the diabetes detection and control centre at Grady Memorial Hospital, Atlanta, Ga., is described. By June 1976, two physician/nurse/dietitian teams had collected a complete problem-oriented data base for each of 6,000 patients. They had formulated 6,000 initial treatment plans and carried out intensive education. Details are given of the procedures followed and the care given.

909. MERRY, J. **An alcoholism service.** *British Medical Journal*, London, 1978, Jan. 21, vol. i, pp. 161-162.

The alcoholism unit described is a self-contained part of the psychiatric department of Epsom District Hospital, Surrey. Before patients are admitted they are detoxified and during their six week stay in the unit, drink, tranquillizers and hypnotics are forbidden, except in a few cases. The in-patient programme consists of daily discussions attended by patients, some partners, ex-patients and members of staff. One day a week patients help to entertain long-stay patients at West Park Hospital. Ex-patients are encouraged to maintain contact with the unit and a 24-hour service is provided for patients in relapse. Of the 100 first admissions in 1975, 53 showed an improvement in their quality of life in a one-year follow-up study.

INTENSIVE CARE UNITS

See also Abstract Nos. 807, 918, 930-932, 939

910. ALENTA, H. P. Las unidades de cuidados intensivos. **[Intensive care units.]** *Policlinica*, Barcelona, 1977, Nov./Dec., no. 42, pp. 22-24, 27-28, 31, 34, 36.

The author outlines the theory of progressive care (from domiciliary, and out-patient, to intensive) and describes the features of intensive care (IC) and the types of patient who require it. The equipment needed and the design, layout, and location of the hospital IC unit are examined. The description is accompanied by eight figures originally published in other countries and four tables which summarize the staffing requirements, the advantages and disadvantages of IC units, a three-stage plan for installing an IC unit, and specifications for electrical and electronic installations. The author emphasises the need for careful reflection on the part of society in general before costly IC units are installed, particularly in countries such as Spain where an adequate system of primary care does not yet exist.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract No. 908

911. REGENSTREIF, D. I. **Innovation in hospital based ambulatory care: some sources, patterns, and implications of change.** *Human Organization*, Boulder, 1977, vol. 36, no. 1, pp. 43-49.

In July 1972 the Genesee Hospital, Rochester, N.Y., closed its traditional out-patient clinic and transferred responsibility for its out-patients to the Genesee Health Service (GHS), a newly created multispecialty group practice composed of salaried physicians. GHS became one of three new centres for health care delivery within the federally-funded Rochester Health Network. GHS and the emergency room were placed under the supervision of a director of ambulatory services. This paper documents the development of these innovations and considers the implications they have for further change, in which the hospital is a focal element.

912. MCNEAL, B. **Program helps managers monitor, analyze ambulatory care activity.** *Hospitals*, Chicago, 1977, Oct. 1, vol. 51, no. 19, pp. 103-104, 106-108.

In November 1974, the W. K. Kellogg Foundation awarded a grant to the Hospital Research and Educational Trust to develop a national comparative data and information reporting programme that would enable acute general hospitals to monitor and analyse staffing, productivity, revenue, expenses and services in ambulatory care areas. To date the major emphasis has been the development of a data reporting programme and its integration into the American Hospital Associations, Hospital Administrative Services (HAS) programme. Collection and presentation of data in the Hospital Administrative Services for Ambulatory Care (HAS/AC) programme are outlined;

they follow closely those of the parent programme. Examples from monthly reports and of departmental indicators from a field test of HAS/AC in 43 hospitals are reproduced.

CASUALTY AND ACCIDENT

913. SHAW, C. **Emergency department use and abuse.** *Dimensions in Health Service*, Toronto, 1977, Dec., vol. 54, no. 12, pp. 10-11.

The author claims that emergency departments are being used for the wrong reasons and recommends that a committee, representing both the hospital and the community, should compile an admission policy for the department, defining how, by whom and under what conditions it is to be used. There must be a specified alternative for all the cases excluded. Patients often find it more convenient to visit a hospital rather than their general practitioner for a number of reasons. Greater co-ordination of hospital services with others in the community and an increased provision of community health centres would help this problem. Emergency treatment is one of the cheapest items covered by medical insurance in Canada. If the same inexpensive cover were extended to the same service given by a general practitioner, the patient would have less incentive to use the emergency department inappropriately.

914. **Delivery of emergency medical services in disasters.** *Mass Emergencies*, Amsterdam, 1977, Sept., vol. 2, no. 3, pp. 135-202.

All eight papers in this issue of *Mass Emergencies* deal with the delivery of emergency medical services (EMS) in natural or technological disasters, resulting in a high number of casualties. The first paper concentrates on the practical side of one particular disaster plan, while the last is more concerned with the development of a scientific theoretical base for the EMS field as a whole. Two papers describe the studies carried out by the Disaster Research Center at Ohio State University, the second providing a summary of substantive findings after one year of research. Another paper by staff from the Disaster Research Center emphasizes the importance of assessing need when a disaster occurs. The remaining three papers discuss: (i) federal funding of emergency medical services; (ii) the co-ordination of the various services responding to mass casualty disasters; and (iii) the centralization of responses to such disasters. This collection of papers shows that much is being learned, both through research and practical experience, about the handling of large-scale medical emergencies.

915. WILKINSON, A. and others. **Attendance at a London casualty department.** *Journal of the Royal College of General Practitioners*, London, 1977, Dec., vol. 27, no. 185, pp. 727-733.

Of patients who attended the casualty department of the Middlesex Hospital during one week in November 1973, 546 were interviewed. The majority were young and worked near to the hospital. One third of the attendances were by patients who had been asked to return. About half the new patients came of their own accord, and most of the remainder were sent by an employer or occupational health service. One third of the first attenders were asked to return and 35 per cent of both groups were discharged. Half the attendances were for treatment of injuries and of the patients who came of their own volition, 57 per cent came as a result of trauma and 24 per cent had

superficial wounds. Nearly half the first attenders required simple nursing procedures. One fifth of the patients had no general practitioner to consult, because of geographical mobility or failure to register. The main reasons given for not consulting a general practitioner were: (i) hospital treatment was felt to be necessary; and (ii) it was more convenient to come to the hospital. A casualty department offers a valuable service in a commercial centre where social circumstances may determine whether or not a patient can conveniently visit a general practitioner.

916. SEMPLE, P. d'A. **Emergency medical admissions—collated data.** *Health Bulletin*, Edinburgh, 1977, Nov., vol. 35, no. 6, pp. 335-338.

Of the 306 emergency admissions to a general medical unit at the Southern General Hospital, Glasgow, 194 were referred by general practitioners, 75 were irregular referrals, 29 were referred by the doctor deputizing services (DDS) and a few from other sources. The standard of referrals by both general practitioners and the DDS was high and the pre-admission diagnosis was in agreement with the discharge diagnosis in most cases. Most irregular referrals were cases of self-poisoning or sudden organic illness while away from home, and only a few were caused by inadequate general practitioner coverage. The average length of stay of the emergency patients was 12 days and delay in the discharge or transfer of patients was a rare occurrence.

917. MAULL, K. I. and HAYNES, B. W. **The integrated trauma service concept** *Journal of the American College of Emergency Physicians*, Lansing, 1977, Nov., vol. 6, no. 11, pp. 497-499.

An integrated trauma service uses existing hospital manpower and services, together with supporting emergency services in the area. The basic trauma team must include a general surgeon, neurosurgeon, orthopaedic surgeon and anaesthetists, with willing co-operation from other specialists. The design and operation of the emergency department is vital to successful trauma management. The involvement of the trauma service begins with resuscitation and assessment of the patient and extends to further care, management of the consequences of injury, and rehabilitation. At the Cook County Hospital, Chicago, injuries involving one or two body systems indicate admission to the trauma service, except for patients with an unstable cervical spine injury, or a deteriorating neurological condition. Educational courses for the staff, data collection covering all stages of trauma care, and a multi-disciplinary clinic for follow-up care all greatly enhance the overall efficiency of the service.

DAY HOSPITALS

See Abstract No. 925

CHEST

See also Abstract No. 932

918. WORLD HEALTH ORGANIZATION. **Regional Office for Europe. Intensive care for respiratory insufficiency: report on a working group, Nancy, 21-23 April 1976. (ICP/OCD/003)** Copenhagen, WHO, Regional Office for Europe, 1977, 33pp.

The aim of the working group was to define acute respiratory insufficiency and its

clinical and functional aspects; describe the main features of the high risk patient; indicate methods of treatment; set out the basic principles of the organizing of an intensive care unit and the requirements for its proper functioning; identify factors helpful in preventing a first attack; and to try to assess the prevalence of acute respiratory insufficiency with a view to establishing as accurately as possible the needs resulting from it. General recommendations by the working group are included in the report together with a list of participants.

INFECTIOUS DISEASES AND ISOLATION

See Abstract No. 882

CHILDREN

919. GREEN, M. and GREEN, J. G. **The parent care pavilion.** *Children Today*, Washington, 1977, Sept./Oct., vol. 6, no. 5, pp. 5-8, 36.

The parent care pavilion at the James Whitcomb Riley Hospital for Children, Indianapolis, has 12 rooms each with a bed for the child, a single or twin beds for the parent(s), and a bath and shower. A colourful curtain can be used to screen off the parent's sleeping area. The pavilion has a large play/dining area, parents' lounge, nursing station and laundry room. Parents and children eat together. The unit is staffed by a head nurse, two full-time registered nurses and a ward clerk. The kinds of problems for which children are admitted to the unit where their parents (usually mothers) can look after them are listed. Patients who can be managed wholly on an ambulatory basis are not admitted to the unit. The advantages of parent care are discussed and some suggestions made for other hospitals contemplating the establishment of such a unit.

920. OSWIN, M. **Physically handicapped children in long-stay hospitals.** *Child Care Health and Development*, Oxford, 1977, Sept./Oct., vol. 3, no. 5, pp. 349-355.

There are approximately 6,500 physically and/or mentally handicapped children living permanently in long-stay hospitals in England and Wales. This paper is based on some of the findings of a two-year study into the care of 223 multiply handicapped children in eight mental handicap hospitals. The study revealed a lack of treatment services, such as speech therapy and physiotherapy. The children are also likely to suffer emotional distress because there is a grave shortage of nursing staff and very little understanding about the mothering needs of children in institutions.

921. BERGER, E. and FRIEDRICH, M. H. Bedarfsschätzung für den stationären Bereich der Neuropsychiatrie des Kindes-und Jugendalters. **[Assessment of need for the in-patient unit of neuropsychiatry for children and young people.]** *Mitteilungen der Österreichischen Sanitätsverwaltung*, Wien, 1977, Nov. 15, vol. 78, no. 11, pp. 300-310.

A detailed survey and study of published statistics on facilities in Austria for the care of children and young people in the specialty of neuropsychiatry shows that there

is a gross deficiency of suitable hospital beds. While the bed requirement for the whole of Austria is estimated to be 1,798 there are at present only 500 beds (270 of them in Vienna). Future planning has therefore to meet the following requirements: the creation of university hospitals or departments of neuropsychiatry for children and young people; provision of such departments in general hospitals, children's hospitals and special hospitals; the appointment of consultants in this specialty to treat patients in other hospitals; and the provision of facilities for long-stay in-patients. Although the primary concern of this paper is the needs of short-term and medium-term patients the requirements of long-term patients have to be taken into account.

922. SIANTZ, M. L. de LEON. **The nurse and the developmentally disabled adolescent.** Baltimore & London, University Park Press, 1977, xiii, 248pp. £6.25

This book provides an integrated and comprehensive approach for identifying, planning and managing the problems of developmentally disabled adolescents. Areas considered included: nurses' responsibility in adolescence; physical development; psychological concepts; the adolescent and the family; the adolescent and the community; special education needs; dental needs; nutrition and nutrition education needs; vocational needs; sex education; the path to adulthood; and future development. Each chapter provides a bibliography and selected readings.

GERIATRICS AND LONG-STAY

See also Abstract No. 933

923. VAN DEN HEUVEL, W. J. A. Overleven vs overlijden in het verpleegtehuis. **[Survival versus death in nursing homes.]** *Tijdschrift voor Sociale Geneeskunde*, Amstelveen, 1977, Oct. 26, vol. 55, no. 21, pp. 754-760; English summary, p. 760.

Several gerontological studies of psychological and social factors relevant to longevity of patients in nursing-homes are discussed. Results are presented of a similar study investigating differences between patients who survived and those who died in nursing-homes within one year. The admission policy of nursing-homes can partly account for the differences found in this study. Knowledge of differences in activities, contacts and needs, can be beneficial to the support given to these patients.

924. HEATH, J. **Care of the elderly: a guide for personnel involved in teaching in hospital and community.** Sheffield, NHS Learning Resources Unit, 1977, [iv], 73pp. £2.50

This teacher's guide is prepared as an aid for staff concerned with the teaching of the care of the elderly, both in hospital and in the community. It consists of two parts; the first considers the general framework of concepts and the broad objectives relating to the main themes. Methods and media are suggested to carry out the teaching/learning process. The second part presents available resource material. Lists of codes, reports, journal articles and useful addresses are presented together with an annotated list of audio-visual material giving details of source, availability, length of film and date of production.

925. XANDER, L. Möglichkeiten zur Darstellung und Projektion quantitativer Beziehungen zwischen teilstationären und stationären Einrichtungen der geriatrischen Versorgung. **[Possibilities of representing and projecting quantitative relationships between in-patient facilities and day time facilities for geriatric care.]** *Das Öffentliche Gesundheitswesen*, Stuttgart, 1978, Jan., vol. 40, no. 1, pp. 33-44.

As part of a research project on facilities for after-care and rehabilitation being carried out by the Technical University of Berlin a simulation model, using an IBM 370/158 computer and 'Dynamo' simulation language is being developed. The objective is to study the interrelationships between full in-patient care, day hospital care and other services (e.g., home care, out-patient care, general practitioner services and home helps) for geriatric patients, and how the results can help in the optimal planning of such facilities and in relieving the strain on acute hospital beds. The four structural components of the model are: population development; patient categories; hospital care; and facilities and measures for relieving hospitals (as listed above). Since the necessary basic data did not exist in Western Germany statistics from Great Britain (the Hospital In-Patient Enquiry and some regional figures) were used for the first phase of the project (modelling the present situation) which has now been completed. The two further stages to be completed are: adapting the model for Western Germany; and a projection, having regard to population development and other dynamic factors. The model should be effective in planning the need for day places: an extension of the model to other facilities for the elderly should help in implementing an integrated service for the elderly.

926. CAPE, R. D. T. and others. **Square pegs in round holes: a study of residents in long-term institutions in London, Ont.** *Canadian Medical Association Journal*, Ottawa, 1977, Dec. 3, vol. 117, no. 11, pp. 1284-1287.

A large random sample of people (731) in long-stay institutions in London, Ontario, was studied to assess their suitability (according to physical and mental status) for the institution in which each resided. The results indicated a relative need for beds in homes for the aged and nursing homes rather than continuing care hospitals. A high proportion (29 to 54 per cent) of the sample were unsuitably placed. Greater flexibility is needed in instituional arrangements, and institutions should be examined for their potential to provide support in maintaining the elderly at home. The findings of the study add some weight to the arguments of those calling for more and better home care programmes for the disabled.

927. SHULMAN, K. and ARIE, T. **Fall in admission rate of old people to psychiatric units.** *British Medical Journal*, London, 1978, Jan. 21, vol. i, pp. 156-158.

Admission rates of old people to psychiatric hospitals in England and Wales started to fall in 1970 and were still falling in 1974. There is no evidence that the incidence of dementia in the elderly is decreasing and lower admission rates could be due to the following: (i) improvements in community care; (ii) more effective psychogeriatric services; (iii) alternative residential care; and (iv) increased admission to geriatric units. However, psycho-geriatric services vary from area to area and cannot cope with the severely demented. The most probable explanation for the falling admission rates is the reluctance of psychiatrists to admit new elderly patients to overcrowded hospitals which

have come under scrutiny following the Ely Report of 1969. Those who need to be in hospital should not be excluded through lack of resources or fear of criticism.

CANCER

928. SOUKOP, M. and CALMAN, K. C. **Cancer patients: where do they die—an analysis.** *Practitioner*, London, 1977, Dec., vol. 219, no. 1314, pp. 883-888.

Over a period of 18 months all deaths in patients attending the clinical oncology department of the Western Infirmary, Glasgow, were reviewed. The aim of the study was to try to identify factors that influence hospital admission for patients with terminal malignant illness. Of the 50 patients concerned, 24 died at home and 26 in hospital; no deaths occurred in a terminal care home. The factors that regulate admission to hospital are multiple. Even with the best will possible on the part of the relatives and with a psychologically well-adjusted patient who wishes to die at home, that objective may be defeated by symptoms requiring hospital admission. Alternatively, the simple lack of any relatives may lead to admission, in the absence of marked symptoms, as the patient's ability for self-care declines. For this reason the authors have attempted to provide a resumé of these factors in order to obtain a better idea of patient requirements.

NEUROLOGY AND NEUROSURGERY

See Abstract Nos. 857, 921

EAR, NOSE AND THROAT

See Abstract No. 907

CARDIOLOGY

929. MORCH, C. and others. **Improved attendance at follow-up clinics.** *Dimensions in Health Service*, Toronto, 1977, Oct., vol. 54, no. 10, pp. 24, 27.

An administrative charge was introduced in a follow-up clinic for young adults with a congenital heart defect, at Toronto General Hospital. About two weeks before an appointment a reminder note is sent to patients with a returnable tear-off section stating if they can attend, and if not, which date would be more convenient. An immediate rise in attendance took place and the rate has been maintained over a period of three years. Savings in administrative clinic costs have also persisted, as well as the benefits to the patients' health.

930. BLOOM, B. S., JONSSON, E. and DOLK, M.-L. **Utilization of coronary care units in Sweden.** *Scandinavian Journal of Social Medicine*, Stockholm, 1977, vol. 5, no. 3, pp. 141-144.

The 26 hospitals in Sweden having definable coronary care units (CCUs) were stratified into regional, county and community hospitals. Two hospitals in each

group were selected for study, which included all patients admitted to the units during 1974. Data recorded for each patient included age, diagnosis at discharge from the unit, length of stay in the unit, and death or survival in the unit. The results showed that larger units in teaching hospitals had significantly lower age-adjusted mortality rates, higher proportions of myocardial infarction patients, and greater productivity and efficiency. Comparison with a study from the United States showed better results in the Swedish units according to all variables measured. Although proof of effectiveness of CCUs is lacking, their continued use is assured. A less than optimal solution is a rational distribution of units based upon epidemiologically determined need, while stressing good organization and efficiency.

931. BEAMISH, R. E. and MICHAELS, L. **Ambulant management of patients with recent myocardial infarction.** *Canadian Medical Association Journal*, Ottawa, 1977, Nov. 5, vol. 117, no. 9, pp. 1017-1019.

Thirty-two patients who had remained active after suffering an acute myocardial infarction were observed closely for six months. Half the patients had no history of cardiac disease and six had previously suffered an infarction. Abnormal physical findings were observed in only seven patients at diagnosis and 27 were managed at home, most continuing normal activities. One patient died, 26 remained free of complications and of the six who developed complications, all but two were as well after the six-month period as before the attack. There were no recurrences among the 31 surviving patients. It is concluded that, for selected cases of acute myocardial infarction, admission to a coronary care unit and close observation need not be equated with prolonged immobility. The patients can be allowed moderate, and with the continued absence of complications, increased activity.

932. SOORIYAARACHCHI, G. S. **Cardiopulmonary resuscitation service in a general hospital in Britain.** *Resuscitation*, London, 1976/77, vol. 5, no. 4, pp. 241-247.

The experience of a cardiopulmonary resuscitation programme (CPR) in a small general hospital (St. Helens Hospital, Merseyside), is reported. The organization of the CPR team and the assembly of the equipment is described. Over a period of seven months, 25 resuscitation attempts were made on 22 patients. The initial success rate was 52 per cent: 32 per cent of patients survived for more than 24 hours and 18 per cent were discharged alive. These figures compare favourably with other series of patients reported in the literature. An organized CPR programme is valuable in any hospital, irrespective of size. It can be achieved with a limited number of staff and basic equipment, given a well trained team and standardized procedures and techniques. The training of the team, and of the other members of the medical and nursing staff, is important for the success of the service, and ways in which this can be achieved are described.

ORTHOPAEDICS

933. DEVAS, M. **Geriatric orthopaedics.** London, Academic Press, 1977, xiv, 200pp. £8.50

This book is an account of the methods used in Hastings, East Sussex, now famous for its geriatric orthopaedic service which is considered as a model of co-operation

between orthopaedic surgeons and physicians in general medicine. The book demonstrates that with close teamwork and shared responsibility, often from the time of admission, the two specialties can bring both viewpoints to bear on the patient—to his ultimate benefit from the improved management and treatment. Aspects considered include: general principles; medical care; anaesthesia; resuscitation; diabetes, rheumatoid arthritis and arthritis; fractures; amputation; and the geriatric orthopaedic unit at Hastings.

UROLOGY

See also Abstract No. 884

934. GRAHAM, A. G. **Scottish prostates: a 6-year review.** *British Journal of Urology*, Edinburgh, 1977, vol. 49, no. 7, pp. 679-682.

This review of the operation of prostatectomy in Scotland is based on the Scottish Consultant Review of In-patient Statistics (SCRIPS) for the period 1969 to 1974. Between 1969 and 1972 the number of operations per annum rose from 1,038 to 1,647 and then remained fairly constant. Figures are given for the three types of prostatectomy used. The general mortality trend is downwards and the length of post-operative stay has been reduced during the period of review. The proportion of patients admitted as emergencies increased in 1974, indicating that patients were having to wait longer for surgery. This increase was also associated with a slightly higher mortality rate for suprapubic protastectomy. The increased use of transurethral surgery is both continuing and desirable, particularly in view of the heavy demand for urological beds.

935. WENDLAND, K.-L. and LOOCK, W. Untersuchungen zum Problem der Rehabilitation von terminal nieren-insuffizienten Kranken unter den Bedingungen der Langzeit-Hämodialyse. **[Studies of problems in the rehabilitation of patients with terminal renal failure under chronic haemodialysis conditions.]** *Rehabilitation*, Stuttgart, 1977, Nov., vol. 16, no. 4, pp. 223-228.

The effect of long-term dialysis on 27 patients with chronic renal insufficiency was assessed with the aid of the Minnesota Multiphasic Personality Inventory. Almost all complained of physical illness attributable to brain function disorders resulting from dialysis. The following conditions were recorded: depression; lifelessness; reduced adaptation to change; hysteria; tendency to regressive behaviour; and increase in use of defence mechanisms. Physical complaints were significantly reduced after the introduction of short-time dialysis and it is hoped that this technique will increase the prospects of rehabilitation.

VENEREAL DISEASE

936. SMITH, E. S. O. **An overview of venereal disease programs in Britain, West Germany, Denmark, and Sweden, with implications for Canada.** *Bulletin of the Pan American Health Organization*, Washington, 1976, vol. 10, no. 4, pp. 321-332.

Even in a limited geographical area such as Western Europe, marked variations exist in many major areas of venereal disease programmes. This paper reviews

programmes in four countries, points out similarities and differences between them, and notes various approaches that might advance the campaign against venereal disease in the author's own country—Canada. The aspects covered include: incidence rates and trends; reporting disease cases; treatment services; treatment of minors; contact tracing; and health education.

SURGERY

937. LIESS, M. and PAQUEL, N. La pratique de la chirurgie dans les secteurs public et privé d'hospitalisation: essai de comparaison. **[Surgery in public and private hospitals: a comparison.]** *Gestions Hospitalières*, Mantes, 1977, Nov., no. 170, pp. 793-800, 802.

This is an account of an attempt to analyse differences between the public and private sectors as regards type of operation performed; it is based on the analysis of activity on a single day in 1972. The method employed is described and the findings presented in 11 tables. As anticipated, the volume of minor surgery and of major operations was greater in the public sector, while the private profit-making sector concentrated on surgery of medium complexity, which generally required the services of one surgeon and one assistant only. Activity was more intensive overall in the private sector. The significance of these findings is briefly discussed.

938. GRAHAM, D. F. **Computer-aided prediction of gangrenous and perforating appendicitis.** *British Medical Journal*, London, 1977, Nov. 26, vol. ii, pp. 1375-1377.

The clinical details of 100 patients with acute appendicitis were compared with those of 100 patients with perforating or gangrenous appendicitis. The information was fed into a computer data base for appendicitis and compared with details of a large number of patients. A clinical scoring index was also used, based on seven features of the differences between the two groups. Twenty symptoms and signs were found to occur significantly more often in one or other of the two groups. The computer correctly diagnosed 93.5 per cent of the acute appendicitis cases and 91.1 per cent of the perforating or gangrenous cases. The clinical scoring index gave an overall prediction accuracy of 88.5 per cent. Computer-aided diagnosis, or the use of a clinical index, is known to increase diagnostic accuracy in appendicitis, and where the probability of perforation or gangrene is predicted, surgery should be performed without delay.

939. BENTLEY, S., MURPHY, F. and DUDLEY, H. **Perceived noise in surgical wards and an intensive care area: an objective analysis.** *British Medical Journal*, London, 1977, Dec. 10, vol. ii, pp. 1503-1506.

Noise levels were measured during five 24-hour weekday periods in a general surgical ward, a cubicle off the ward and an intensive therapy unit (ITU). Chart recordings were analysed in half-hour time periods. Neither the ward nor the ITU were as quiet as a bedroom at night and throughout the 24 hours the ITU was usually noisier than a living room. Loud noises (above 70 dB(A)) were common in both areas, but especially in the ITU where the main sources of noise were equipment and conversations amongst the staff. Although measures designed to eliminate noisy surfaces are helpful, noise peaks are most often made by the human voice and staff

should be made aware of the noise they create and the effect it may have on patient welfare. An appendix on the technique of noise measurement is included.

MATERNITY

940. KEAY, A. J. and SIMPSON, R. McD. **Prevention of infection in nurseries for the newborn.** *Postgraduate Medical Journal*, Oxford, 1977, Oct., vol. 53, no. 624, pp. 583-587.

Prevention of infection in nurseries involves consideration of the design of hospitals, wards and equipment, the study of nursing and domestic procedures, and the monitoring of environmental flora and planning of antiseptic and antibiotic policies. The degree of safety for infants depends upon the extent to which each individual involved in their care pays attention to the agreed policies of general and personal hygiene.

PSYCHIATRY

See also Abstract Nos. 808, 820, 909, 920-922, 926-927

941. BOWDEN, P. **The current management of the mentally disordered offender.** *Proceedings of the Royal Society of Medicine*, London, 1977, Dec., vol. 70, no. 12, pp. 881-884.

An examination of the work of a remand prison (Brixton, which serves the four Thames regions) in the disposal of mentally abnormal offenders is reported. Two of the many factors which influenced the medical recommendation were examined first: the facilities available in a region and the attitudes and practices of its consultant psychiatrists. In the first case the presence of a locked ward and the size of the hospital were found to be important. Most psychiatrists practised the forensic aspect of psychiatry, but there was evidence of specialization. Over a three-month period in 1975, every fifth man (126 in all) remanded to the prison for medical report was included in a survey. The sample was remarkable for two characteristics: a high incidence of recidivism and repeated admissions to psychiatric hospitals. A follow-up study of the 82 men who actually went to hospital indicated a low level of need for security in the treatment of mentally abnormal offenders, selected for their potential for violence. The implications of these findings are discussed.

942. GUNN, J. **Management of the mentally abnormal offender.** *Proceedings of the Royal Society of Medicine*, London, 1977, Dec., vol. 70, no. 12, pp. 877, 880.

Failure to provide the secure units recommended in 1961 has led to a crisis in the management of mentally abnormal offenders. The history of events in the South East Thames Region suggests that finance is not the only reason that not a single secure unit has been built. Misunderstanding of staff attitudes on the one hand and a lack of debate about the possible development of a third service on the other hand may have contributed to the fact that no substantial developments have taken place yet. Security re-organization can use an integrated model, a parallel model or a mixture of both. In the absence of experience it is difficult to be certain which is correct, but it is contended

that it would be a mistake to apply one blueprint to the whole country. Given the shortage of funds and the reluctance of some regions to develop security policies, perhaps the best tactic is to fall back on administrative empiricism, encourage developments by adequate funds but allow different schemes to develop in different regions so that disparate knowledge can be accumulated gradually.

943. MORRISON, A. **Sectorisation of psychiatric services: ten years' experience in Fife.** *Health Bulletin*, Edinburgh, 1977, Nov., vol. 35, no. 6, pp. 329-335.

Sectorization of psychiatric services, that is, the provision of services for designated sectors within a catchment area, has been in operation in Fife for the last 10 years. Many factors had to be considered in forming the sectors, including: (i) movement of population; (ii) location of industry; and (iii) accessibility of hospitals and clinics. The development of three community based sectors and the organization of out-patient facilities proved straightforward. The more complex problem of the integration of treatment and rehabilitation facilities was solved by the establishment of a common short-term unit of 100 beds, but with separate psychogeriatric admission and assessment units and long-stay wards for each sector. Sectorization of community services and psychogeriatric units has resulted in a reduction in waiting lists in all but one sector. Each sector has a stable nucleus of experienced staff, but Stratheden remains the administrative centre of the service as a whole.

944. MUNRO, J. D. **Avoiding front-line collapse within mental retardation facilities utilizing an alternative consultative approach.** *Canada's Mental Health*, Ottawa, 1977, Sept., vol. 25, no. 3, pp. 10-12.

Staff concerned with treatment and direct care of patients in psychiatric institutions often lose their motivation and may become abusive to the patients. Consultants and other specialists rarely give the 'front-line' staff the support they need, nor do they understand the practical problems such staff encounter. The author suggests that the consultant should be on hand in one ward or unit, rather than trying to serve many such units. While retaining his consultative duties, he should work the 'front-line' staff as a team. 'Front-line' consultation increases the consultant's job satisfaction and improves the quality of treatment and training given to patients. However, administrators should be aware that not all consultants want 'front-line' roles and that some, if given such a role, might overpower the other staff.

945. GRANT, G. W. B. and MOORES, B. **Resident characteristics and staff behaviour in two hospitals for mentally retarded adults.** *American Journal of Mental Deficiency*, Albany, N.Y., 1977, Nov., vol. 82, no. 3, pp. 259-265.

This paper reports part of a study aimed at evaluating the implications of varying staffing levels in hospitals for the mentally handicapped. Two samples of 30 patients were observed in two hospitals and measures were obtained of the proportion of time they were involved in adaptive and maladaptive activities, the frequency with which they interacted in particular ways with the nursing staff, and the adaptive behaviour scale scores. The results indicate that a greater proportion of the interactions received by residents with higher assessed levels of independence, higher observed adaptive

behaviour levels and lower levels of social maladaption, promote warmth or positive development. Staffing levels has no effect on this pattern of interaction. While such results are understandable and even perhaps predictable, they reveal a situation deserving remedial attention. It is suggested that one possible means of countering the tendency to ignore the less attractive patients is for nursing staff to be assigned much smaller groups of patients than is customary.

946. GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **In-patient statistics from the Mental Health Enquiry for England, 1975 (Statistical and Research Report Series No. 20)** London, Her Majesty's Stationery Office, 1978, [ii], 139pp. £3.75

This report of the in-patient statistics collected from the Mental Health Enquiry contains detailed tables of the 1975 statistics and less detailed trend tables giving information for several years from 1964 onwards. Commentaries have also been included on the latter tables to assist interpretation of the statistics. The four areas considered are: mental illness hospitals and units; mental handicap hospitals and units; special hospitals; and legal status. A paper by J. A. Grimes on 'The Probability of Admission to a Mental Illness Hospital or Unit' examines the likelihood of a person being admitted to a mental illness hospital or unit at some time in his life, on the basis of 1975 admission rates. Four appendices are included covering: population tables; notes on completion of record forms for psychiatric hospitals; the classification and coding of types of hospitals, mental category and diagnoses; and a list of official publications.

947. CARNEY, M. W. P. and NOLAN, P. A. **Area security unit in a psychiatric hospital.** *British Medical Journal*, London, 1978, Jan. 7, vol. i, pp. 27-28.

A psychiatric hospital security unit at Shenley Hospital, Herts., which also serves the Northwick Park and Central Middlesex Hospitals' catchment areas, cares for mentally ill patients with disturbed behaviour. Two wards offer different degrees of security: one houses patients who are occasionally harmful, and the other takes patients with short-term behaviour problems and a number of longer stay patients. The admission of women to the unit in 1976 did not lead to the expected reduction in violence. The unit has facilities for occupational therapy, physical recreation, work and study. The calming influence of the unit depends as much on the supportive effect of the high staff ratio as on tranquillising drugs. This type of unit cannot be used for mentally abnormal offenders, but it can act as a short-term centre for the disturbed mental patient, and there is an increasing demand for its services.

948. CLARK, D. H. **The therapeutic community.** *British Journal of Psychiatry*, Ashford, 1977, Dec., vol. 131, pp. 553-564.

The years from 1960 to 1976 have seen interesting developments in the practice and standing of the therapeutic community. The main purpose of this paper is to describe and analyse these trends, to review the literature, and to consider the position in 1976. A list of 45 references to the literature is included.

949. PALMER, J. W., KUSHLICK, A. and DAWES, B. J. **Evaluation of locally based hospital units for the mentally handicapped in Wessex: report on professionals' following of rules, some consequences for clients, and changes in demand for residential care (Research Report No.123)** Winchester, Health Care Evaluation Research Team, [1977], ii, 45 [28]pp.

A system of residential care has been tested in the Wessex region in which there are specific rules requiring all patients of a certain severe degree of disability to be transferred to locally based hospital units serving territories defined according to epidemiological data. Possible ways in which clients of small local units might suffer disadvantage are considered. If the predictions based on epidemiological data are adequate, service managers can design, provide and staff a single unit to cater for a known number of clients with specified behavioural repertoires. Additional aspects considered include: historical development of the locally-based hospital units, and the methods and results of the research team's study of the Wessex units, including experimental design and intervention. A select list of references is included.

950. WOULFE, D. **The physical environment of the mentally handicapped. XIV—what can a designer offer?** *British Journal of Mental Subnormality*, Birmingham, 1977, Dec., vol. 23, no. 2, pp. 95-103.

Following an approach by a hospital, the School of Interior Design at Birmingham Polytechnic agreed to design an environment for mentally handicapped boys of both high and low dependency, on the assumption that the environment would offer them opportunities for greater happiness, greater learning potential, greater training potential, more effective use of the nursing and care available, and the beginnings of some personal and even private life. In other words to offer them through the contribution of a better environment as much normality of life as they could grasp. This paper discusses how this and other designs were produced and what resulted.

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